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 January 2021
28 January 2021
29 January 2021

Date of publication:
20 April 2021

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Phoenix Residential Care Home is a residential care home providing personal care to 13 people aged 65 and over at the time of the inspection, one of the 13 people was in hospital. The service provides care and accommodation to younger adults, older adults and people living with dementia as well as other health conditions. The service can support up to 18 people.

People's experience of using this service and what we found
Although some improvements had been made since we last inspected the service, there continued to be serious shortfalls in the service provided to people. Some improvements previously made had not been sustained.

Most staff knew people well. Whilst we observed caring, friendly interactions between staff and people, we also observed interactions which demonstrated that people were not treated with dignity and respect.

Individual risks were not always assessed and managed to keep people safe. Staff did not always follow the guidance in people's risk assessments. When people had accidents and incidents, care plans and risk assessments had been reviewed and amended. However, action had not always been taken in a timely manner which put people at risk of harm. Some people were at risk of falls, and although risk assessments were in place, they had not been updated following subsequent falls.

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

People could not be assured there were enough staff on duty at night to make sure they could be evacuated safely if an emergency such as a fire took place. The level of staffing during the day had improved. The provider had employed a housekeeper, an activities staff member and care staff. People could not be assured new staff were adequately checked to ensure they were suitable to work with people to keep them safe. Although staff training had improved, there were still areas for concern where people may not have skilled staff on duty to provide their care.

Although care plans had improved, there continued to be areas that needed to improve to make sure people received care and support in the way they wanted and needed. Some people received inconsistent care and support with their continence needs.

The management and oversight of the service was still not robust enough to identify areas of concern and put actions in place to continuously improve quality and safety. Since the last inspection, the provider had employed a new consultant to help them improve the service. The consultant had been involved since mid-November 2020. Improvements that had been made needed to be embedded and then sustained. Some improvements found at our last inspection in November 2020 had not been sustained. This was the 10th

inspection where the provider had not achieved a rating of good and the sixth consecutive rating of inadequate.

People were not always safeguarded from the risk of abuse. People had not always received healthcare from professionals when they needed it.

We were not fully assured that the provider's infection prevention and control policy was up to date. Staff wore appropriate personal protective equipment such as masks, gloves and aprons to keep themselves and people safe.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice. We made a recommendation about this.

People did not always have choices of meals at each mealtime. Despite easy to read pictorial menus being available at the last inspection, the use of these had not been embedded into day to day practice. Staff did not use these to help people make a choice of food at each meal and the pictures were not left on display to help people remember what the menu options were.

Improvements had been made to accessible information within the service to help people to understand information, choices and be involved in their care and support. This was not yet embedded. We made a recommendation about this.

People attended meetings to discuss the service and other important information. Those who did not attend were given opportunities individually to be involved after the meeting.

Medicines management had improved. People's prescribed medicines were managed in a safe way. There were some further improvements required in relation to as and when required medicines.

Fire safety had improved, however their remained outstanding fire safety works. The premises were cleaner and was free from odours. Some areas of the service had undergone redecoration. Some work had been done with people and their relatives to make bedrooms more personal.

People and their relatives had not made any complaints since the last inspection. People and some relatives had completed surveys of their care and experiences. The provider had started to take action to address the feedback gained. People now had more activities to prevent them from being bored. People now had some opportunities to follow their interests and were offered meaningful occupation to prevent social isolation and maintain their well-being. The provider had received a few compliments. These included one from a relative who had been sent pictures of their loved one enjoying their birthday. The relative said, 'Bless you guys for looking after her so well and giving her the hugs that I can't.'

Some changes to end of life care plans had been made since the last inspection. Some people and their families had been encouraged and supported to discuss their choices and preferences.

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

Rating at last inspection and update
The last rating for this service was Inadequate (published 24 November 2020).

The provider completed an action plan after the last inspection and each week thereafter to show what they would do and by when to improve.

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

Why we inspected
We undertook this inspection to gain an updated view of the care and support people received. This was a planned inspection based on the previous rating. We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

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

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

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

We have identified continued breaches in relation to regulations 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and new breaches in relation to regulations 9, 10, 13 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 always effective.

Details are in our effective findings below.

Requires Improvement

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 always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Phoenix Residential Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

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

Service and service type
Phoenix Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

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

Notice of inspection
The first day of the inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority who work with the service, and the local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. Healthwatch told us they had not visited the service or received any comments or concerns since the last inspection. A local authority commissioner told us they were continuing to carry out monitoring of the service. We used all of this information to plan our inspection.

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

During the inspection
We spoke with four people who used the service about their experience of the care provided. Some people were not able to verbally express their experiences of living at the service. We observed staff interactions with people and observed care and support in communal areas. We also spoke with three relatives. We spoke with 11 members of staff including the provider, the deputy manager, team leaders, support workers, housekeeper, cook and agency staff.

We reviewed a range of records. This included six people's care records and a selection of people's medicines records. We looked at two staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

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

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

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

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

● The provider had updated, and improved people's care files and individual risk assessments had improved since the last inspection. Staff now had guidance to follow to help them to take appropriate preventative measures when people were at risk.
● We found staff support did not always follow the guidance in people's risk assessments. One person was at risk of choking and had been advised by a health care professional to sit upright when eating their food. The healthcare professional advised staff must closely observe the person at all times when eating. Although this guidance was very clear within their risk assessment, we observed that some staff were not following the guidance to safely support the person with their meals as advised. This meant the person was at considerable risk of choking. We raised this with the provider who was unaware of the poor practice. They said they would speak with all staff and commence a monitoring regime to check staff practice.
● Some people were at risk of falls, and although risk assessments were in place, they had not been updated following subsequent falls. One person had fallen in November 2020 after our last inspection, they had sustained an injury that required hospital treatment. The provider had reviewed the person's risk assessment on 18 December 2020 but had not included information about the fall and injury. A new falls risk assessment had been added to the person's file which was blank.
● A number of accidents and incidents had been recorded since the last inspection, mainly falls. Some incidents had not been recorded. We identified an incident in January 2021 when we were looking at daily records. However, this had not been recorded appropriately as an incident. A near miss was observed during the inspection. When we checked records the next day, the incident had not been included in any records. We told the provider about this who had not been made aware by staff. They said they would speak with staff to ensure appropriate reporting and accurate recording.
● Although the provider checked accidents and incidents each month, this had not resulted in a reduction in falls and people remained at risk. The provider had not used the recording of accidents and incidents to closely investigate repeat falls to review preventative measures in place. The opportunity had not always been taken to learn lessons to improve outcomes for people.

● Although much of the work to rectify fire safety issues had been completed at the last inspection, work remained outstanding to rectify fire risks such as removing ceiling tiles and compartmentation. This work remained outstanding at this inspection.

The failure to provide safe care and treatment by reducing risks to people's health and safety is a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Personal Emergency Evacuation Plans (PEEP's) had improved. Staff and the emergency services now had the information necessary about individuals and the support they needed to evacuate the premises in an emergency.
● At the last inspection, some people were prescribed emollient creams which were highly flammable, and this had not been identified as a risk. At this inspection, people who had been prescribed creams that could be flammable had a risk assessment in place with safety measures to keep them safe.
● People now had an individual COVID-19 risk assessment to record how people may be affected by COVID-19 and to provide staff with the guidance they needed to try to prevent the spread of infection.
● Relatives told us they felt their loved ones were safe at the service. One relative said, "[My loved one] is safe and comfortable there and most importantly they seem happy and settled."

Systems and processes to safeguard people from the risk of abuse
● The provider had not taken an objective view to concerns raised by a whistle-blower two weeks before this inspection. This meant a full investigation had not been completed into the issues raised. The provider had cooperated with the local authority safeguarding team and responded to the questions raised within the timescales given. However, some areas were presumed rather than fully investigated.
● We found evidence during our visit the areas of concern raised by the whistle-blower were issues that needed to be addressed. The provider had not taken action before our visit to check if improvements needed to be made to keep people safe.
● One person had fallen over equipment in a communal area. A safeguarding referral had not been made to the local authority safeguarding team. The nature of the fall meant healthcare advice should have been taken straight away. The provider told us staff had tried to contact NHS 111 but had not been able to get through due to the service experiencing a high number of calls. This was not recorded in the person's daily notes, although a note had been made on the accident form. No other healthcare advice was sought, such as from the GP, when the NHS 111 service was unavailable.

The failure to ensure people are safeguarded from abuse and improper treatment is a breach of Regulation 13 (Safeguarding Service Users from Abuse and Improper Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

● Staff were able to describe their responsibilities in safeguarding people in their care. They knew how to raise concerns outside of the organisation if necessary.

Medicines management

At our last inspection the provider failed to take appropriate action to ensure medicines were managed in a safe way. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements had been made since the last inspection and the provider was no longer in breach of this

area of the regulation, although some improvement was still needed.

● Protocols for safe administration of as and when necessary medicines (PRN) were now in place. This meant staff administering medicines had the information necessary to give people their medicines when they needed them. One person was prescribed pain relief PRN. The person was living with dementia and not able to verbally articulate pain. Their care plan recorded they may rub their knee or limp, however, medicines records did not give an indication how to identify if the person had pain. Their medicine administration record (MAR) showed they were given pain relief three times a day most days in January 2021. No record was made why the medicine was given and how the staff member had concluded pain relief was required. This is an area for improvement.
● At the last inspection, one person was prescribed a laxative to prevent constipation which could impact on their health. The person was not given the medicine regularly as they were refusing. Medical advice had not been sought. At this inspection, the provider had liaised with the GP to change their prescribed laxative to 'as and when necessary'. However, they had still not been supported to take the medicine regularly to maintain their bowel function. The person's records evidenced that they had frequently opened their bowels except for a period of four consecutive days. The PRN protocol did not identify at what point staff must encourage the person to take their laxative. The person remained at risk of constipation as they had been given their laxative only twice during January 2021. A consistent approach had not been taken by staff on these occasions. This is an area for improvement.

● At the last inspection a countdown sheet was being used by staff to check how many medicines were left in stock. However, the amounts of medicines left were not being counted and we found discrepancies in numbers left in stock. At this inspection, people's medicines were counted regularly, and we found no discrepancies in numbers in stock versus the numbers recorded on the countdown sheets.
● At the last inspection, the provider had not maintained accurate medicines records for disposal for medicines. At this inspection, accurate records had been maintained.

Staffing and recruitment

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

Improvements had been made at this inspection; however, the improvements were not enough to meet the breach. The provider was still in breach of Regulation 18.

● At previous inspections, the staffing rota showed there were not enough staff on shift at night to be able to safely evacuate people according to their assessed needs. At this inspection, the staffing levels at night had not yet been reviewed and remained the same. Some people's PEEP's stated they needed one member of staff to stay with them once evacuated from the building to keep them safe. Other people needed two staff to help them evacuate the building. Only two staff were on duty during the night. □
● New staff had been recruited and were in the latter stages of the recruitment process. Some agency staff were used to provide safe cover in the meantime. However, a number of staff were working long hours to cover the shortfalls in the rota and some were working night shifts or extra day shifts on their day off. Rotas showed that some night staff had worked up to 11 consecutive nights which were 12-hour shifts, without adequate rest time. A staff member was observed attending training in the afternoon at the service on 28 January 2021 on their day off. The rota then showed that they worked a night shift on the same night. This meant staff may not be well rested and at risk of becoming unwell or at risk of providing care below a good

standard. One staff member told us, "We get very tired and that's not good for people's care." Another staff commented, "Staff turnover is high. They come and go."

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

● At the last inspection the provider was in the process of reviewing how they assessed people's needs to base their staffing levels on accurate information. At this inspection, they had started to use a recognised tool to enable their decision making. This showed the numbers of staff on shift through the daytime were sufficient to meet current people's needs.
● At the last inspection, a team leader and a cleaner had recently left. This meant the provider was working long hours without sufficient breaks to help to cover the team leader vacancy. At that inspection, the provider had not made improvements to the poor cleanliness of the service due to the frequent lack of cleaning staff. Care staff had not been sufficiently deployed to support these vacancies. At this inspection, a new team leader was in post and a new cleaner. However there remained vacant posts for night and day staff.

● Recruitment checks for new staff applications had improved at the last inspection. At this inspection, this area had deteriorated. Gaps in employment history were found in one new applicant's application, including their CV. References had been followed up to check new applicants were suitable for their role. However, the provider had contacted referees by telephone and there was no evidence to suggest the referees were valid as they had not asked for a form of verification such as email confirmation.

The provider has failed to sustain the improvements to recruitment practice found at the last inspection. The failure to ensure staff were recruited safely into the service by completing the appropriate checks was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A Disclosure and Barring Service (DBS) check had been completed before new staff members started their employment. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.
● The provider had interviewed new staff to make sure they were suitable to work with people living in the service. Proof of identity, such as current address and passport or driving licence checks were completed.

Preventing and controlling infection

At our last inspection, the provider had failed to ensure the service was clean and properly maintained. This was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, the service was cleaner and odour free. The provider was no longer in breach of regulation 15. However, we were not fully assured about some areas of infection control in relation to Covid-19.

● We were somewhat assured that the provider was preventing visitors from catching and spreading infections. Safety measures to take when professionals and people other than relatives were visiting the service were not clear.
● We were somewhat assured that the provider was admitting people safely to the service. When people were readmitted to the service and did not follow isolation guidance, a risk assessment was not undertaken

to make sure preventative measures protected other people in the home from infection.

● We were somewhat assured that the provider's infection prevention and control policy was up to date. The policies and procedures in place relating to COVID-19 needed amendment to make sure government guidance was adhered to by staff.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

We have also signposted the provider to resources to develop their approach. After the inspection, the provider took action to address the areas where we were somewhat assured.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

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

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

● At the last inspection, although people's care plans were detailed, they had not been reviewed and updated to reflect changes in need. At this inspection, all care plans had been reviewed and updated.
● At the last inspection, some people's needs and how they received support had changed, and care plans had not been updated to reflect the changes. At this inspection, most care plans reflected people's current needs. However, one person had been having difficulty swallowing and had been coughing whilst eating, they had choked on food on two occasions in January 2021. Their eating and drinking care plan had not been updated to include that the person required monitoring whilst eating and drinking, in line with changes that had been made to their risk assessment. We observed the person eating their meal on 28 January 2021 and found them to be eating unsupervised and they were coughing. We reported this to the provider and advised them to seek urgent advice from the person's GP. The provider did this and then updated the care plan.
● At the last inspection, the provider had introduced an additional tool to assess people's nutritional needs. The two tools sometimes gave conflicting results. At this inspection, the provider was using one tool. This enabled the provider to keep track of people's nutritional needs.
● People's falls risks had not always been adequately assessed. New falls risk assessments were in place. However, they had not always been completed correctly. One person's falls risk had been reviewed on 25 November 2020 and again on 20 January 2021. The assessment had been incorrectly scored because the assessment had not included information about the person's diagnosis of dementia. Another person's falls assessment had been incorrectly scored as it had stated the person was not prescribed four or more medicines per day, when their medicines records showed they were.
● One person's needs had not been fully assessed. The person spent a lot of time in bed and was known to occasionally have red areas appear on their skin which needed treatment. The risks in relation to pressure sores had not been assessed to enable staff to regularly monitor.

The failure to ensure accurate records are kept to ensure people's care and support is safe and meets their

needs is a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff support: induction, training, skills and experience

● The provider had not sourced training in a timely manner when issues and concerns had been identified. There had been a delay in gaining dysphagia training for staff. Dysphagia is the medical term for swallowing difficulties. One person's choking risk assessment which was dated 26 September 2020 stated that dysphagia training was to be delivered to all staff. The provider had not actioned sourcing this training until 28 January 2021 as a result of concerns we raised during the inspection (in relation to observations of staff practice). The provider had identified in their accident and incident investigation following a person's fall on 13 December 2020 that updated moving and handling training was required. The training records evidenced that this had not taken place for all staff.

● Some new staff had not undertaken fire training or fire drills. This meant that they may not fully understand the fire procedures and how to evacuate people safely.

● Staff told us they received an induction which included meeting people, reading files and training. However, staff induction records did not evidence that training and reviewing of care files to enable them to understand people's care needs had taken place. The rotas the provider sent us evidenced that after a two-hour induction new staff were then placed onto shift, without having time to shadow experienced staff. Some new staff had attended training however, staff had worked on shift prior to receiving the essential training they required for their roles.

The provider has failed to sustain improvements to training which had previously been made. The failure to ensure that staff were competent and skilled to carry out their duties is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● Staff who had worked for the provider for some time had continued to update their training by completing courses online. End of life care training was being delivered by external trainers to a small group of staff when we inspected.

● The provider and staff told us that no supervision meetings have taken place since the last inspection. The provider was planning to carry these out in February 2021.

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

● It was not always clear that people had gained medical input from healthcare professionals when they required it. One person's daily records evidenced they were found on the floor. Their daily records indicated they were very tired and not acting in their usual manner for the rest of that day. However, no action was taken to investigate the reason for the fall and its effect on the person. This meant the person's health needs had not been fully investigated and met.

● We reported to the provider that one person had not had diabetic eye screening or an optician's appointment since October 2019. Their diabetes had deteriorated since that time, which would increase the risks associated with eye health. After we inspected the provider arranged for a follow up eye screening appointment for the person. The same person required specialist six monthly appointments at the hospital to meet a different medical need. The appointments had been cancelled because of the COVID-19 pandemic, however there had been no discussion with specialists or the GP about the impact of these cancellations on the person.

● Some people were living with diabetes; therefore, it was extremely important that they had regular foot care and foot checks. People's care records did not document that they had seen a chiropodist. The provider told us the chiropodist had been to the service and provided some receipts for this. However,

receipts were missing, and it was not clear if people had been seen by the chiropodist in December 2020 or January 2021. The provider told us after the inspection that the chiropodist visited on 04 February 2021.
● There had been delays in taking action in a timely manner. One person had a choking incident on 21 January 2021 and the provider had made a speech and language therapy (SALT) referral to gain specialist assessment and advice. However, the same person had choked 10 days before the incident and records showed that the person had been coughing whilst eating. The provider had not requested SALT advice following this first incident. Which increased the risks of choking on foods that may not be suitable. The provider had not spoken with the GP to gain interim guidance whilst waiting for SALT to assess the person. We discussed this with the provider during the inspection and they gained advice and made changes to the texture of food as a result of the advice gained.

The failure to ensure relevant healthcare professionals were involved in people's care and treatment is a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People had choices of meals at lunchtimes five days out of seven per week. On the days where roast dinners were on the menu, no second choices were given. Teatime menus showed that there was only one choice of meal. People's meal records showed that sometimes people had only eaten a very small amount or that they had refused their meal. Records did not evidence that people had been offered an alternative meal to meet their needs. This is an area for improvement.
● People continued to be supported to maintain their nutrition and hydration needs. Staff kept good records of how much people had eaten and the snacks they had between meals. Staff now clearly encouraged people to drink plenty of fluids and recorded the amounts people had drunk in the day. Fluid intake was added up and team leaders monitored the amounts at the end of the day to make sure people were drinking enough to maintain their health.
● Some people were advised to have a soft diet due to swallowing difficulties or were at risk of choking. Some people had diabetes so needed to be aware of the amount of sugar in their diet. Peoples' dietary needs and likes and dislikes were not clearly recorded, the list was outdated and did not include changes to people's assessed needs. We reported this to the provider, who updated the information for staff working in the kitchen. The cook knew people well and could describe the consistency of people's foods, the size of plate they preferred and what foods people liked best.
● People continued to choose where they ate their meals. Although most people ate in the dining room, some people chose to eat in their room, or in the conservatory. People told us they enjoyed a choice of home-cooked meals. A relative commented, "[My loved one] always has plenty of praise for the staff and for the food."

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

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

At this inspection some improvements had been made, the provider had met the breach of Regulation 15. However, there remained some areas for further improvement.

● The environment had undergone some minor changes since the last inspection. Some redecoration had taken place. The service continued to need updating to provide a better maintained and better presented

environment for people to live in. There remained plans in place to redecorate the service and fix areas that had been damaged in early 2020 following a water leak; and work to replace doors. A window at the front of the service on the first floor remained boarded up.

● At the last inspection, we reported that the provider had started to work with some people's relatives to make people's rooms more personalised. At this inspection, this work had continued, records showed that a member of staff had been working with people to make their rooms more personalised. Some people were working on memory boxes for their rooms. A relative told us they had brought in some furnishings to make their loved one's room more personalised.

● At the last inspection, the smoking area for people was on a patio and had still not had a covered area installed to protect people from poor weather. At this inspection this was still outstanding. However, the risk had reduced as people who smoked were not smoking as much and were not seen using the space.

● Dementia friendly signage remained in place to help people orientate around the service.

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

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

At this inspection some improvements had been made, the provider had met the breach of Regulation 11. However, there remained some areas for further improvement.

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.

● At the last inspection, no changes had been made to capacity and consent records. At this inspection, each person's mental capacity had been assessed in relation to specific decisions. Best interest decision making processes had not always been fully recorded as to when other people such as relatives or social workers had been involved in the decision making. We spoke with a relative who did not recall being involved in a best interest decision, despite documentation stating they were involved.

● At the last inspection, people had the opportunity to have a flu vaccination. MCA assessments and best interest decision making had not recorded what information the provider had taken into account and how they had come to the decision had not been recorded. At this inspection, 11 out of 13 people had received their COVID-19 vaccination. Records showed that one person had declined their vaccine. The provider had completed a mental capacity assessment for people who required it. A best interests decision making process had been recorded. However, the process was not robust, for example, to capture the person's views about vaccinations in their life before they lost capacity to consent to treatment. The provider

confirmed they had not used easy read information to support people to make their decision.

We recommend the provider consider current guidance on MCA and best interest decisions to update their practice accordingly.

● At the last inspection care plans still did not provide clear guidance to staff to ensure the protection of people's rights where people had a DoLS authorisation. At this inspection, DoLS conditions were now embedded in care plans, which meant staff had the information they needed to understand what they needed to do to meet the legal requirements.
● A relative told us, "[My loved one] has a DoLS. It was discussed with me. They rang me and talked about them having the vaccine too. I feel involved in his care."

Requires Improvement

Is the service caring?

Our findings

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

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

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

- At the last inspection we reported that the service had consistently been rated requires improvement or inadequate. At this inspection the rating continued to be inadequate overall. This meant people were not consistently receiving good care.
- One person's fingernails were very long and not cared for. We asked them about their fingernails to find out if this was their preference and they said some had broken off. All their fingernails were still long despite this but some much longer than others. We spoke to the provider about this who said they would make sure the person's fingernails were cut.
- Staff interactions with people when they were sitting in communal areas had improved. We observed staff asking people what music they would like played in the background. When people chose a song, this was played and people were happy, singing along. However, this was not consistent, on one occasion we observed a staff member setting up the music based on a discussion with people and putting this on. People were enjoying the music, tapping their hands and feet and singing. Another staff member entered the room, switched the music right down to ask a question and then left the room without putting the music back on for people. The music was left off for 45 minutes which left the people in the room sat in silence. When the music was eventually put back on people were immediately singing, sat more upright and people were once again tapping fingers in time to the music.
- People who had been supported to get out of bed later in the day because they had chosen to have a lay in were not given the option to evenly space out their meals. On one day of the inspection we observed one person being supported to the dining room at 10:50 in the morning to have their breakfast. Lunch was being served early on this day as staff were going to be receiving training. The person was supported to the conservatory and was eating lunch at 12:15, this was less than one and a half hours after they had started their breakfast. Another person's records showed they were supported to get up, washed and dressed at 11:58 one morning and had their breakfast shortly afterwards. They then had their lunch 30 minutes later.
- People were involved in making choices about day to day things such as what drinks, snacks, food and activities they wanted. It was not always clear from records that choices were always offered. Wording used within a staff meeting records evidenced the service was 'Trialling decaf coffee for residents at night to help them get back to sleep if they wake asking for coffee. Horlicks was not very popular as a substitute'.
- During the inspection, we saw instances where people's dignity was compromised which led to a lack of respect. A staff member had not checked that one person they were supporting was in a position of maintaining their privacy and dignity in a communal area. The staff member was unaware until we pointed

it out to them. Another staff member supported a person with removing food from the person's mouth whilst the person was sat at the dining table, other people were sat at the same table and were eating at the time.

● Some people needed support with their continence needs. Some people's daily records did not provide assurances that staff provided consistent and regular support to maintain their comfort and dignity. One person's records showed they had not received continence support for up to seven hours at times. Another person's records showed that they had not received continence support for up to 12 hours and 20 minutes. A further person had not received continence support for up to 10 hours and 30 minutes. This person's records had evidenced that when there had been long periods of time in between continence support, the person needed additional support to clean up and get changed.

● People's care records contained a personal history plan which described basic details of their lives, such as family, places they had lived, jobs they had held and hobbies and interests they had. People's care records did not include other important information which may have a bearing on their care and support needs such as their sexuality, gender, religion and culture.

The failure to treat people with dignity and respect is a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● The atmosphere in the service had improved. People did not look bored, as they had during previous inspections. People sitting in the lounge looked more alert and engaged in what was going on around them. Some were chatting with each other and singing together.

● One person showed they preferred to eat their meals in the conservatory and staff respected this, making sure the space was available for them to eat their food.

● Relatives told us, "[My loved one] has always been treated with kindness and respect whenever I have been there" and "Overall, I am really pleased with the care [my loved one] gets. They seem to be caring."

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

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

At the inspection, 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 some improvements had been made, the provider had met the breach of Regulation 17. However, there remained some areas for further improvement.

● At the last inspection the provider had only updated and reviewed two out of 13 people's care records. At this inspection, each person's care plan had been reviewed and updated. Care plans were in place for people in relation to specific needs such as diabetes, osteoporosis, epilepsy and catheter care.
● Some care plans required further improvements, so staff had all the information they needed to provide care. For example, continence care plans required more details to record how often a person required continence care. Oral hygiene care plans required additional detail so that staff knew how many times a day a person required support with their oral hygiene. One person spent most of their time in their room and needed lots of encouragement to get out of bed. Their care plans recorded staff should visit their room between 8:00am and 8:00pm to have regular chats. However, more specific guidance was not given to staff, such as how often 'regular' was. The support the person received in relation to communication and to prevent social isolation was not consistent as not all staff provided the same level of encouragement. Most communication was only during meal or snack times. Staff did not visit the person in their room at other times. We saw this through our own observations during the inspection. We checked the person's records which confirmed similar patterns on other days.
● Where people shared a diagnosis such as diabetes, it was clear care plans were not always person centred as it referred to other people by name or referred to the wrong sex. The provider had picked up some of these issues through their auditing processes and sometimes this had been missed.
● One person's care plan recorded they loved to see family and friends and their face lit up when they visited. The person was living with dementia and they were not able to verbally articulate their feelings. Visits by loved ones were clearly very important to them. However, the person's records did not go on to provide guidance to staff how they should support the person to maintain their close relationships during the times their loved ones couldn't visit, such as the COVID-19 pandemic.
● The lack of up to date records meant people may not always get the person-centred care and support they needed from staff to maintain their health and well-being. Agency staff were being used to cover a staff sickness and where staff were required to isolate. The provider had recruited new staff, which meant it was

crucial people's care records were maintained with up to date information.

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 the last inspection, people's care plans and most information was not available in accessible formats such as easy read, pictorial and large print. The provider had included this in their improvement plan but had not progressed. At this inspection, some improvement had been made. One person with a diagnosis of dementia had an easy read version of their care plan in their care records. Other people living with dementia did not have these in place.
● Despite easy to read pictorial menus being available at the last inspection, the use of these had not been embedded into day to day practice. Staff did not use these to help people make a choice of food at each meal and the pictures were not left on display to help people remember what the menu options were.
● At the last inspection there was no easy read complaints procedure. At this inspection, an easy read complaints procedure was in place in an accessible information file. This was not on display for people to be able to access readily if they wished.

We recommend the provider consider current guidance on accessible communications to update their practice accordingly.

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
● Activities within the service had improved since the last inspection. A new activity staff member had been employed five afternoons a week and we observed structured activities taking place with a large selection of people who utilised the communal areas. The activity staff member supported people to engage and participate at their own pace and recognised when people liked to watch and listen rather than physically take part.
● There was less structure to activities for people who chose to stay in their bedrooms. The provider and activity staff member told us about the plans to progress activities further. The activity staff member had already spoken with people who chose to stay in their rooms about their hobbies, interests and likes and dislikes and had planned to try different things to support more engagement to reduce social isolation.
● At the last inspection the previous activity lead had started to work through activity books with three people and were looking to extend this to more people. At this inspection, this had stopped. However, the new activity staff member had been given the information about the activity books by the provider during the inspection and had planned to reintroduce this.
● Activity records evidenced that people had been involved in activities such as quizzes, cooking, music and dancing, arts and crafts, bingo and putting names to faces and crosswords. We observed people engaged with activities such as indoor skittles, hangman and singing and dancing. People were smiling, happy and engaged.
● People's relatives told us, "I have spoken to [my loved one] a few times on the phone, although he probably forgets about it quite quickly. I write letters to him as well", "They have done really well with [my loved one], he now goes downstairs and joins in with things" and "I speak to [my loved one] on the phone. Staff are really good, and I get photos sent to me."

Improving care quality in response to complaints or concerns
● At the last inspection, the provider had not received any formal complaints. At this inspection, the provider

told us again no formal complaints had been received. We had not received any complaints about the service at CQC and the relatives we spoke with said they had not made any complaints.

● We observed people chatting with the provider and staff, which indicated they would speak with them if they had a complaint. People were given opportunities in their monthly meeting with the provider to discuss any concerns or complaints. The meeting records for 07 January 2021 evidenced that one person had raised they were missing seeing their relatives. This led to a discussion about COVID-19 and vaccinations.

● Relatives felt confident to raise any complaint with the provider and felt action would be taken. They did not have any complaints about the service.

End of life care and support

● No people were receiving end of life care at the time of this inspection. People had an end of life care plan. Some changes to end of life care plans had been made since the last inspection.

● Some people and their families had been encouraged and supported to discuss their preferences further, beyond where they would like to be towards the end of their life, for example, at Phoenix Residential Care Home or hospital. Their wishes and preferences had been documented and where people had been involved, they had signed the documentation.

● Staff knew people and their relatives well and knew people's preferences. The provider told us relatives would be able to visit during the pandemic, through receiving personal protective equipment and a rapid COVID-19 test, if their loved ones were nearing the end of their life.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

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

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

● At the last inspection, we found that although some improvements had been made, people continued to be at risk of harm as many areas had not improved. At this inspection, further improvements had been made. The provider had assessed and recorded individual risks and how to minimise these. However, improvements did not go far enough in responding quickly to changes in people's needs and the associated risks. Intervention was not always timely enough to keep people safe.
● Although improved, the provider still did not always have oversight of the service, and care being provided by staff. They had spent time updating records and ensuring care plans were written in a way that could be better understood by staff. This gave them a better understanding of people's care needs. However, staff were not providing consistently good care, as described through this report, and this had not been recognised by the provider.
● Records were not always complete and accurate. This meant that the provider was not always able to account for actions taken, such as financial transactions, telephone calls to healthcare professionals and records relating to monitoring of people's weights.
● At the last inspection, the audit systems and processes in place were not robust. Whilst the provider had started to improve the service, the improvements had not been embedded. At this inspection, audits were not robust. Audits undertaken by the provider and an external auditor had not always identified areas of concern in this inspection such as safe recruitment practice, risk management, training and records management.
● The provider's audits and checks had not included a review of records and documentation in the kitchen. This meant that the provider was unaware of areas of improvement in relation to pest control records, thermometer calibration and that the cooks information held about people's dietary needs was out of date. Many people's dietary needs had changed.
● After the last inspection the provider had started to submit a weekly improvement plan. This improvement

plan has consistently been sent documenting the provider's actions to make improvements to the care and support people received. At this inspection, we found that many of the areas that the provider had reported as met within their action plan had not been met and further improvements were required. The provider's auditing systems had failed to identify that the improvement plan was not as complete as they had been reporting.

● The provider continued to have a more reactive rather than proactive approach to changes in people's needs and emerging risk. This meant they did not always seek advice about concerns and changes in people's needs in a timely way.

● Accident and incidents had not been fully investigated by the provider to ensure lessons were learnt to prevent similar incidents from happening. During our review of records, we identified possibly themes of falls that had not been taken into account by the provider. This left people at continued risk of further falls. The provider did not closely monitor daily records in conjunction with recorded incidents. This meant some incidents and near misses had not been recorded and the provider was unaware of this until we told them.

● The provider had not taken the opportunity to learn lessons from the concerns raised by a whistle-blower but had discounted some of them. We found evidence that the concerns raised were areas that needed to be addressed and improved.

● At the last inspection, the provider had not taken action to meet the Health and Safety Executive's (HSE) guidance in managing legionella in hot and cold-water systems. At this inspection we again found that the empty room flushing had been completed monthly instead of weekly. This demonstrated that potential risks continued not to be well-managed.

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

● The provider engaged positively with inspectors during and after the inspection. They were open about the areas they needed to make further improvements and were being supported to do this by an independent consultant. The provider said they now better understood their role and the regulatory requirements.

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

● Surveys with people and relatives had been completed and action had been taken to address some of the comments. For example, people had commented about being bored and new activities had been introduced.

● There were regular 'Resident meetings' which people could choose to attend. People who chose not to attend or were unable to attend the meeting were spoken with in their rooms, to ensure their views and experiences were gained.

● The provider held regular staff meetings. This gave staff an opportunity to discuss practice, issues and any concerns and gave the opportunity to share changes, information and reminders.

● The provider had received a compliment from a relative which read, 'To all the staff at Phoenix Care Home. Thank you all for your hard work and dedication. And thank you especially for the care and love shown towards [person] she may be a challenge, but I know she loves you all. Let's hope 2021 is a better year for us all.'

Working in partnership with others

● The provider was a member of various local forums and registered manager social media groups to keep in touch and share experiences and good practice. They had increased their involvement since the last

inspection.
● The provider continued to maintain contact with local authority commissioners and staff as well as health care professionals such as GP's and district nurses.
● Relatives told us they were kept informed about their loved ones. Relatives told us, "Staff ring with the slightest thing so I am kept up to date and involved" and "[Staff] keep me updated with everything."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The provider was more involved in the service which had led to a more positive approach to people's care. This had resulted in an improved atmosphere in the service.
● However, staff feedback was mixed. Many staff had concerns about their employment rights and working conditions and felt they were not able to raise these with the provider. We had spoken with a whistle-blower before the inspection who raised concerns about how they were treated. We found evidence that some of their concerns were justified. Staff felt concerns may not always be acted upon by the provider.
● This meant although improvements had been made, there continued to be areas that needed to be addressed to ensure staff were confident and able to provide a good and safe service to people.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

At the last inspection, the provider failed to notify CQC in a timely manner about incidents that had occurred. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

● At this inspection, the provider had submitted notifications to CQC in a timely manner when notifiable events happened. Registered persons are required to notify CQC without delay of events such as serious injury, deaths, Deprivation of Liberty Safeguards (DoLS) authorisations and allegations of abuse. The provider was no longer in breach of this regulation.
● The provider kept families informed of any concerns and incidents within the service or with their loved one.
● 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.

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 10 HSCA RA Regulations 2014 Dignity and respect The provider has failed to treat people with dignity and respect Regulation 10 (1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider has failed to ensure staff were recruited safely into the service by completing the appropriate checks. Regulation 19 (1)(2)(3)

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 has failed to ensure relevant healthcare professionals were involved in people's care and treatment. Regulation 9 (1)(2)

The enforcement action we took:

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider has failed to provide safe care and treatment by reducing risks to people's health and safety. 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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider has failed to ensure people are safeguarded from abuse and improper treatment. Regulation 13 (1)(2)(3)(4)

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 has failed to ensure a robust approach to improving the quality and safety of the service and failed to ensure that records are accurate, complete and contemporaneous to ensure people's care and support is safe and meets their needs. Regulation 17 (1)(2)

The enforcement action we took:

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider has failed to ensure staff were deployed so people's care needs were met and failed to ensure that staff were competent and skilled to carry out their duties. Regulation 18 (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.