The Serenity Care Company Limited

Serenity House

Inspection report

North Warren Road
Gainsborough
Lincolnshire
DN21 2TU

Tel: 07508232276
Website: www.serenityhome-care.co.uk

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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
Serenity House is a residential care home providing personal care to six people at the time of the inspection. The service can support up to 15 people. The service is registered to support older people, however people with a learning disability and autism were in residence. The service is not registered to support people with these needs.

People's experience of using this service and what we found
The systems in place to assess, monitor and manage risks to people's health, safety and welfare was fragmented and unsafe. Sufficient action was not taken in relation to fire safety risks and risks relating to the ongoing building renovations.

There were significant health and safety risks in relation to the premises and unsafe storage of machinery and equipment. Infection prevention and control procedures did not protect people and staff from the risk of contagious diseases.

People were at risk of harm because risk assessments were not always place for specific risks to people. System to monitor and review risks and support plans was not effective. People were not always involved in the process to assess, develop and review risks and their support plans.

Staffing levels were not always consistent. This meant people did not receive a person-centred approach which included the one to one support they needed. Systems and processes to protect people from the abuse and improper treatment was not robust.

People received their medicines as prescribed. However not all medicines were stored safely. The provider took action following our inspection visit to ensure medicines that needed to be refrigerated were stored securely.

People were mostly supported to have maximum choice and control of their lives and staff mostly supported them in the least restrictive way possible and in their best interests. Although policies were in place the systems were not robust to support this practice.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture. This was because the provider was not aware of the principles and lacked

insight as to the model of care and environment to promote the lives of people with a learning disability. The service was only registered to support older people, despite supporting people with a learning disability and autism in residence. Staff required further training to support people with a learning disability and autism. Support plans were personalised but did not always involve people to ensure their wishes and aspirations were identified to enable staff to promote them to lead confident and inclusive lives.

The provider did not have oversight and systems and processes to assess, monitor and improve the quality of service remained ineffective. Quality assurance systems had not identified widespread issues and risks. This placed people at serious risk of harm.

The provider had not fulfilled their legal responsibilities. Breaches of regulations were found at our inspections of March 2021, November 2019, March 2021 and October 2017. This demonstrated the lack of lessons learned and limited action had been taken to improve the service as further breaches of regulations were found at this inspection.

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 April 2021). We issued a requirement notice in relation to regulation 12 (Safe care and treatment) and a Warning Notice and the provider was required to meet the requirements of regulation 17 (Good governance) by 31 July 2021. The service rating has deteriorated to inadequate. Breaches of legal requirements were found, and the service was placed in special measures. This service has been rated requires improvement for the last four consecutive inspections.

Why we inspected
The inspection was prompted in part due to concerns received about the environmental and fire safety risks, health and safety risks and leadership of the service. We decided to inspect and examine those risks and to check whether the Warning Notice was met. This report only covers our findings in relation to the key questions of Safe and Well-Led which contained the Warning Notice. 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 COVID-19 and other infection outbreaks effectively.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion 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.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Serenity House 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 breaches in relation to safe care and treatment, infection prevention and control,

safeguarding service users from abuse and improper treatment, premises and equipment and governance and quality monitoring. The provider had failed to keep their registration up to date and had failed to submit notifications to the CQC, which they are required to do so by law.

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 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 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?

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.

Serenity House

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.

This was a targeted inspection to check whether the provider had met the requirements of the Warning Notice in relation to Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 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.

Service and service type
Serenity House 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
We reviewed information we had received about the service since the last inspection. We sought feedback

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

During the inspection
We spoke with two people who used the service. We spoke with five members of staff including the provider who is the registered manager, deputy manager, operations manager, a support worker and the house-keeping staff member and who also was one of the director's. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

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

After the inspection
The provider sent evidence to demonstrate the urgent action taken to reduce environmental and fire safety risks to keep people safe.

We spoke with a staff member, two people who used the service and four relatives. We looked at training data and quality assurance records. We continued to seek clarification from the provider to validate evidence found. We sought further information and feedback from the local authority.

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.

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.

Assessing risk, safety monitoring and management

- At the last inspection fire safety risks were found. At this inspection we found more fire safety risks due to the ongoing building renovations. Fire safety equipment was not readily available in all areas. Fire safety equipment were not secured to the walls and could be moved easily. The fire risk assessment and individual evacuation plans were not updated as people were relocated to different bedrooms and some areas were restricted. This put people at risk of harm should a fire break out at the service.
- Risks associated with people's individual physical health and conditions were not always assessed and kept under review. There was no specific risk assessment for a person at risk of choking. Information in support plans was contradictory and differed to how staff actually supported a person at risk of choking and the information about the suitable textures required.
- People told us they could access all areas of the service but were asked not to touch the building equipment and material left lying around. Relatives said, "It is old, shabby and ill kept" and "It needs cleaning up a bit. It is so hard with bits [building material] lying around."

The provider failed to ensure care and treatment was always provided in a safe way and risks were not managed. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

- There were significant risks and dangers to people due to the ongoing building renovations. There were ill-fitted fire doors and fire exits. There were nails on the floor, sharp edges, exposed floors and uneven surfaces which posed risk of trips or falls. Electrical cables were not secured and presented a ligature risk. Windows were not secure or safe. Some windows were missing, ill-fitted and were not fitted with restrictors to deter unwanted intruders. Machinery and garden tools were not stored securely outside and could be easily accessed. The provider had not taken sufficient action to reduce risks to people.

The provider had not ensured people were protected against the risks associated with unsafe or unsuitable premises. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

● One person said, "Fire tests happen all the time. We have to get out of the house" and added that staff would help them to exit the building safely.
● Following our inspection visit the provider took urgent action to reduce environmental and fire safety risks. They provided assurances that there were sufficient numbers of staff to meet people's needs and keep them safe. We continue to monitor this as risks to people remains due to the premises.

Preventing and controlling infection
● Improvements were needed to reduce the risk of cross infection. There was dust, dirt and debris throughout including on clothing and bed linen. There was new and old exposed plastered walls and exposed floor boards. There was significant infection control risks in the laundry room. There was damp and mould corridor and carpet which had extended to an occupied bedroom. Soft furnishing and sofas were dirty and fabric on the chairs had damaged outer covers. This meant people and staff were exposed to the risk of cross infection, which could cause serious harm.
● We were not assured that the provider's infection prevention and control policy was kept under review and updated as changes were made to the premises.
● We were not assured staff and management implemented fully practice to prevent the spread of contagious diseases. We did not see staff frequently cleaning the high-risk surfaces and the toilets after people had used them. This meant people were at risk of acquiring contagious diseases.

The provider had not ensured people were protected from the risk of infectious diseases. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was using PPE effectively and safely and staff were trained to use PPE correctly.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance. This include telephone contact and window visiting had been encouraged. Where people went on home visits family members were encouraged to be tested and monitored for symptoms of COVID-19.

Staffing and recruitment
● The provider did not maintain adequate numbers of staff. Staff and relatives said, they were short staffed mostly on weekends. Comments included, "Some days they have been short staff" and "[person] is very much one-to-one and if it doesn't happen, I have known [person] in the past kick off [display behaviours that challenge]."
● The provider's dependency tool calculated the number of staff needed to support people. However, the worked rotas showed some shifts had not been adequately staff and unplanned staff absences were not always managed. This meant people did not receive the care and support they needed. Staff regularly worked long hours and consecutive shifts with minimal rest periods as agency staff were not used. This meant people's safety was put at risk because there were not enough staff available to support people as required and to keep them safe.
● New staff had been recruited, but none had started in their role as the provider announced the service was to close.

The provider failed to ensure there were enough staff deployed to meet people's needs. 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 recruitment procedures had improved and records confirmed pre-employment and identity checks were carried out. They included a check with the Disclosure and Barring Service which helped to support safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse

● People were not always protected from the risk of abuse. One person told us "[Person] was not nice to me and hits me. I told [staff] who made sure [person] stayed away from me." The person told us they felt unsafe when the other person was near them.

● The provider did not have robust systems in place to ensure safeguarding procedures were followed. The management and staff meeting minutes made reference to incidents of a safeguarding nature which resulted in harm or risk of harm and abuse. No action had been taken to reduce the risk of reoccurrence. Safeguarding referrals had not been made to the local authority and the Care Quality Commission were not notified. This meant safeguarding procedure had not been followed and people were not protected from further risk of harm and abuse.

● People were at risk of having their liberties unnecessarily deprived without the appropriate authority. Staff told us everyone had a Deprivation of Liberty Safeguard (DoLS) authorisation in place but could not describe what the DoLS was for and their role in supporting people.

● Records showed people's DoLS had expired and there was no evidence to show whether appropriate capacity assessments or best interest decisions had been completed relating to safe care and treatment. This meant people were at risk of receiving improper treatment and were not protected from the risk of abuse.

People were at risk of abuse and having their liberty unduly deprived because robust safeguarding procedures were not followed. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Medicines that needed to be refrigerated were stored securely in the domestic fridge and could be accessed by unauthorised staff and people involved in meal preparation. The daily fridge temperatures were not monitored to ensure the medicines were stored within the manufactures recommended safe temperature range to remain effective when used. The provider took swift action following the site visit. The medicines were stored in a metal lockable box and daily temperatures were monitored twice a day.

● Staff involved in handling medicines had received training and records showed their competency had been assessed before they could administer medicine.

● People told us they received their medicines on prescribed. Support plans provided sufficient guidance for staff to follow as to the level of support people needed. Protocols for medicines to be administered 'as needed' were in place. A sample of the medication administration records viewed showed these were completed in full and were accurate.

Learning lessons when things go wrong

● The system to analyse incidents and accidents was not effective. Accidents and incidents were not always documented and reported correctly. There was little evidence of any investigation to establish the cause or if any learning could be applied to reduce the likelihood of reoccurrence as similar incidents reoccurred such as altercations between people and behaviours that challenged staff.

● The provider had not maintained systems in relation to fire safety and environmental risks whilst the

building renovations were underway, despite concerns raised by the local authority and the fire service. This meant people remained at risk.

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.

At our last inspection the provider had failed to implement effective quality assurance systems to monitor 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. We issued a Warning Notice. The provider was required meet this regulation by 1 July 2021.

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

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

- The provider's oversight of the service remained fragmented. Systems to maintain and monitor health and safety issues within the service remained ineffective. There were significant risks that were not managed in relation to infection control, fire safety, windows and the ongoing building renovations. The fire risk assessments and individual evacuation plans were not kept under review and updated to ensure staff knew what action to take.
- The legionella test had still not been carried out despite assurances given by the provider to the local authority. This demonstrated a continued failure to provide a well-managed and a safe service.
- The quality assurance processes lacked scrutiny and remained ineffective. Audits and checks completed on the premises, infection control and medicines did not identify risks and shortfalls. There was no system to review these audits and checks, and no action plan to monitor the progress of improvements. The provider had no building renovation plan in place to enable them to monitor and manage potential risks.
- Oversight of people's care, risk assessments, support plans and associated records such as incident reports were not effective. There was no system to ensure support plans and risks were kept under review as people's needs changed or following incidents. People's communication needs were not considered when planning their care. This meant people did not receive safe managed care that met their needs.
- The was no system in place to ensure any incidents of a safeguarding nature were responded to appropriately. The local authority and Care Quality Commission (CQC) were not always notified of all incidents where harm or potential abuse had taken place. There was no system in place to monitor and renew people's Deprivation of Liberty Safeguarding (DoLS) authorisations to ensure people were not deprived inappropriately.
- The provider had failed to use the findings from our last four inspections to drive enough improvements. This demonstrated the provider had not consistently met their legal requirements in relation to the continued and further breaches regulations under the Health and Social Care Act 2008.

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

● People and relatives told us they were not aware or fully involved in the development of their support plans. Support plans were not reflective of people's wishes and aspirations and did not consider their communication needs whether easy read or pictorial plans would help the person understand. A relatives said, "[Person] does need support in making decisions. At the beginning [staff] said they would send us a monthly update, and they sent it once and never again."

● We received mixed feedback from people and their relatives as to how the provider sought their views about the service. A suggestion box was in place but people's communication needs had not been considered to ensure information was provided suitable formats for people to understand, such as easy read or pictorial.

● System to ensure staff were trained and supported in their roles was not robust. Records showed staff were not trained to support people with a learning disability and only one staff member had been trained in autism awareness. Staff were not encouraged to share ideas and make suggestions to improve people's quality of life. Staff told us action was not taken when they raised concerns about the environment, staffing levels which put people's lives at risk.

There were continued ineffective systems and processes to ensures effective management oversight of the quality assurance of all aspects of people's care and the service. This was a continued breach of Regulation 17, Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and relatives were confident to approach staff, the deputy manager or the provider if they had any concerns about the care and support provided.

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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The provider had not kept their registration up to date. The service is registered to support older people, however people with a learning disability and autism were in residence.

● The provider was not aware of the underpinning principles of right support, right care, right culture principles and lacked insight as to the model of care and environment. This meant people's human rights and choices to lead confident, independent and fulfilled lives was not promoted.

● The provider had not updated their statement of purpose which set out what the range of services provided and type of care and support people can expect to receive.

This is a breach of regulation 12 Statement of Purpose of the Care Quality Commission (Registration) regulations 2009.

● The provider had not understood their responsibility under the duty of candour to be open and honest when things went wrong.

● The provider and staff and feedback from the local authority confirmed people had Deprivation of Liberty authorisations. We also identified from records we reviewed that incidents and safeguarding concerns were reported. However, the provider had failed to notify the CQC, which they are required to do so by law.

Working in partnership with others

● Following our last inspection the provider sent information to CQC when requested to do so.

● Staff told us they worked with external health and social care professionals and made referrals when people's health was of concern.

● The provider announced the service was to close. The provider and staff continue to support people and work with the local authority to ensure people move to suitable provision of care in a planned way.

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 12 Registration Regulations 2009 (Schedule 3) Statement of purpose The provider had not revised their statement of purpose and notified the Care Quality Commission of changes to the service provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure there were enough staff deployed to meet people's needs.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure risks associated with people's care had been identified, mitigated and monitored. The provider failed to ensure people medicines were stored safely. The provider failed to ensure people were protected from the risk of infection.

The enforcement action we took:

We issued a Notice of Decision to cancel the registration.

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 failed to ensure robust safeguards were in place to protect people from abuse, and the undue deprivation of people's legal and human rights.

The enforcement action we took:

We issued a Notice of Decision to cancel the registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance.

The enforcement action we took:

We issued a Notice of Decision to cancel the registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

The provider had failed to ensure the safe careand treatment of people.

Quality assurance systems were fragmented and ineffective. There was a lack of oversight of people's care, safety and the quality of service.

Risk management process was not robust and people were not protected from harm or potential harm.

The system to maintain adequate staffing and provide support was not robust.

People, relative and staff had limited opportunity to express their views about the service to improve the quality of care.

The system to maintain adequate staffing and provide support was not robust.

The enforcement action we took:

We issued a Notice of Decision to cancel the registration.