Phoenix Residential Care Homes Limited

# Phoenix Residential Care Home

## Inspection report

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## Ratings

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

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

# Summary of findings

## Overall summary

About the service
Phoenix Residential Care Home is a residential care home providing personal care to 13 people aged 65 and over at the time of the inspection. The service provides care and treatment 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.
There continued to be serious shortfalls in the service provided to people.

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

The premises were not clean in all areas and plans had not been put in place to make sure people were living in a service that was kept clean and free from odours. People were not supported to have a homely and individual bedroom to create a pleasant and personal environment.

People could not be assured new staff were adequately checked to ensure they were suitable to work with people to keep them safe.

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

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

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.

Although staff training had improved, there were still areas for concern where people may not have skilled staff on duty to provide their care. The provider had not updated all of their own training.

Infection control practice in relation to the latest COVID-19 government guidance for the use of PPE in care homes was not always followed to keep people and staff safe.

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. Only a few improvements had been made since the last inspection and this was a cause for concern. This was the eighth inspection where the provider

had not achieved a rating of good and the fourth consecutive rating of inadequate.

Staff continued to receive regular individual support meetings and the provider held staff meetings to keep staff up to date.

Improvements had been made to food and fluid monitoring. People received healthcare from professionals when they needed it. Records in relation to healthcare advice and contact were not always complete.

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.

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 01 May 2020) and there were multiple breaches of regulation. The provider produced an action plan in May 2020.

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

Why we inspected
We undertook this focused inspection to gain an updated view of the care and support people received. This was a planned inspection based on the previous rating. This report only covers our findings in relation to the Key Questions Safe, Effective and Well-led.

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

The overall rating for the service has remained inadequate. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvement. Please see the safe, effective and well led sections of this full report.

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 breaches in relation to regulations 11, 12, 15, 17, 18 and 19 at this inspection.

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?**

Inadequate

The service was not safe.

Details are in our safe findings below.

**Is the service effective?**

Inadequate

The service was not effective.

Details are in our effective findings below.

**Is the service well-led?**

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

# Phoenix Residential Care Home

**Detailed findings**

## Background to this inspection

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

Inspection team
The inspection was carried out by 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. 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. The registered manager was also the provider. This means that they are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was announced. We gave the provider less than 24 hours' notice of the inspection. This was to check if any staff or people at the service were positive or had symptoms of COVID-19 and to discuss arrangements for the inspection and PPE required.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority who work with the service, and the local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We reviewed information we had received from the fire service.

We used the information the provider gave us during their emergency support framework (ESF) call. The ESF has been developed by CQC to gain an understanding from providers how the coronavirus (COVID-19) pandemic has affected the service. The ESF is a supportive conversation to share information and review help and support the service may need.

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

During the inspection
We spoke with three people who used the service through video calls and three relatives about their experience of the care provided. We spoke with five members of staff including the provider, the deputy manager, team leader, support workers and the housekeeper.

We reviewed a range of records. This included four people's care records and many medicines 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 monitoring and auditing records were reviewed.

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

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 had failed to robustly assess the risks relating to the health, safety and welfare of people in a number of areas. These included individual risks around fire, choking, ingestion of toiletries and safety concerns relating to the premises such as risk of strangulation from blind cords. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, although some improvements had been made in some areas, we found the failure to identify risks and take actions to reduce them was still of significant concern. The provider remained in breach of regulation 12.

● At the last inspection, one person living with dementia was at risk of ingestion of liquids, such as toiletries which were kept in their bedroom and bathroom. These could cause significant harm if swallowed. At this inspection the person had moved bedrooms and a risk assessment had been updated to detail toiletries should not be kept in their bedroom or bathroom. However, we found a number of toiletries in their unlocked bathroom cabinet, and tubes of toothpaste on an open shelf which would have been in reach. We alerted the provider who immediately removed the items. They were unsure how long the toiletries had been accessible and not been safely stored. Despite the known risk to this person, effective action had not happened to keep them safe.
● One person had choked on water on 01 July 2020. The choking incident had been so serious that staff had called for an ambulance and the person was taken to hospital. The provider had put together a temporary care plan in place to alert staff to the choking incident that had occurred. No risk assessment had been developed to minimise the risks of this happening again and no referral had been made for a swallowing assessment. Risk to this person had not been properly assessed or reduced.
● A person was at risk from placing certain items tightly around their neck and waist. Records showed these should be kept in another room. There was no specific risk assessment in place about this to detail that the person, who lived with dementia, was mobile and had independently mobilised around the service, so other people's items could also be a hazard to the person. Although one staff member we spoke with told us the items were kept elsewhere because they were a danger to the person, there was insufficient guidance available to staff to ensure they knew how to keep them safe.
● Risk assessments had not always been amended and updated when people's needs changed. One person's care records showed they suffered from dry, itchy skin. We observed the person had large dressings on their legs and records showed the community nurses had been treating them for ulcers on their legs, after the person's skin had become broken. The provider had reviewed the person's skin integrity care plan

in June 2020 and had failed to detail that the person had broken skin which the community nurses were treating, which meant that staff did not have updated guidance to provide the person with safe care. There was no guidance on what they needed to do should the person's skin decline further, such as reporting any changes or signs of infection to the community nursing team in between visits. Another person had lost 4.8kgs in weight since January 2020. Their malnutrition assessment had not been calculated correctly based on the person's new weight and BMI. The provider had not identified that the person was now at a higher risk of malnutrition and not referred the person to their GP or on to a dietician.

● At this inspection fire risks which Kent Fire and Rescue Service (KFRS) identified in October 2019, had been partially met. A new fire alarm system had been installed and new fire doors and door seals had been installed. However, fire risks remained in the building because some work had not been completed. The provider told us that this was due to the pressures of the COVID-19 pandemic. We observed that fire doors around the service were propped open with door wedges. The electronic and magnetic door devices were not working, which meant in the case of a fire people would be at risk. KFRS had told the provider they could prop open a small number of doors for a short period in March 2020 because there was electrical work taking place and completion of this was imminent. The provider had been propping the doors open for a period of five months and KFRS were unaware this work had not been completed. We discussed our concerns with the provider during the inspection and they arranged for a contractor to carry out some of the work on 10 August 2020. Although the COVID-19 pandemic may have prevented some works being progressed, there was no reason for fire doors to be propped open in the meantime; placing people at increased risk from fire spreading. There was additional work also outstanding with ceiling tiles and compartmentation that needed addressing. A suitable plan had not been put in place to protect people and the continuing fire risks had not been reassessed.

● An electronic key pad to one of the doors on the first floor of the service was not working. The keypad was designed to prevent people living with dementia and those with mobility difficulties accessing the stairs on their own; where they may be at risk of falls. We spoke with the provider about this and they told us this had not been working since the fire alarm work had taken place as this was linked to the electronic and magnet devices. There was no risk assessment in place to detail how to reduce the risk of people accessing and falling on the stairs.

● Each person had a Personal Emergency Evacuation Plan (PEEP) which had been reviewed since our last inspection. This contained basic information about the level of assistance they would need to reach a place of safety in the event of an emergency. PEEPs did not detail how many staff would be required to support people who had been evacuated out of the building. One person's PEEP recorded they could become anxious. There was no information about what staff should do to reassure the person and support their safe evacuation. Some people lived with dementia and would be at risk of harm if they were left unattended outside if they had been evacuated. After the last inspection the provider had increased the staffing at night. However, this had been reduced again to two members of waking night staff at this inspection, despite the elevated risk from fire safety works not being completed.

● Fire evacuation equipment was in place to aid the evacuation of people who were unable to safely use stairs. Not all staff had completed training on this. Two new staff had been employed since the last evacuation equipment training. The fire drill records for the service showed that there had been two drills since last inspection, despite systems to protect people from fire risks not being fully operational and incomplete essential works. The drills had not included night staff and not all staff employed had taken part. This meant staff and people were at increased risk of harm. Some staff were not confident they would be able to evacuate everyone safely because of the level of support people would need.

● The provider had produced a COVID-19 risk assessment for the service which detailed how they planned to reduce the risks of staff and people contracting COVID-19.This did not include information about isolation practice if people were admitted to or from hospital. The government have produced specific guidance for care homes 'Admission and Care of Residents in a Care Home during COVID-19' which states 'To minimise

the risk to residents in care homes during periods of sustained community transmission, all residents being discharged from hospital or interim care facilities to the care home, and new residents admitted from the community, should be isolated for 14 days within their own room.' One person had been taken to hospital on 30 July 2020 following a fall. They had not received a COVID-19 test since May 2020. We observed this person sitting in the communal area of the service with others on 06 August 2020, this was seven days after their admission to hospital. There was no COVID-19 risk assessment regarding their admission or temporary care plan for this period. Daily records evidenced the person only stayed in their room until 04 August 2020, which was an isolation period of five days. The provider told us that the person had not been isolated for as long as they should have been because they were unhappy and trying to get out of their room. However, the daily records showed staff had reported that the person was happy and content. The failure to isolate people returning from a hospital stay put people and staff at higher risk of contracting COVID-19.
● On 18 August 2020 we video called a selection of people to gain their feedback of living at Phoenix Residential Care Home. During the video call we observed staff were not wearing any face masks which they are required to do as set out in Public Health England's 'Personal protective equipment (PPE) – resource for care workers working in care homes during sustained COVID-19 transmission in England'. The provider had not done everything they could to reduce the risks to people.

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

● The provider had purchased a visor for each relative to use when they visited their loved ones to enable them to spend time and interact without their mouths being obscured by masks.
● At this inspection blind cords were safely tied up to prevent people from becoming tangled and this had reduced the risk of strangulation.
● People told us they felt safe. One person explained that they felt safe when they were hoisted. They said, "I feel safe, I'm fine with the hoist."
● Accidents and incidents were recorded by staff. The provider checked these records, monitored incidents to identify themes and took action to learn lessons and prevent further occurrences. One person had fallen upstairs in the service. With the person and their relative's agreement, they were relocated to a ground floor room which better met their needs.
● Relatives said timely action was taken when accidents and incidents had occurred. A relative told us, "[The provider] said after last week's fall that she would put a sensor in the bed now and this was done by the time we returned from hospital."

Staffing and recruitment

At our last inspection, the provider had failed to ensure staff were deployed so people's care needs and preferences were met. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that the staffing numbers deployed during the day had improved. However, there remained areas for improvement with night staff deployment.

● There were suitable numbers of staff to provide the care and support people were assessed as needing during the day. However, 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. There were two staff on shift at night and at least three people who required two staff to support them with evacuating. Staff identified to us a number of people who would require a staff member to stay with them once evacuated to keep them safe. This meant

that the other staff member would be responsible for evacuating all other people in the service.
● Assessments of staffing levels based on people's needs were undertaken by the provider. However, information used to calculate the assessed needs was inconsistent and conflicting. One person required additional assistance at meal times to enable them to safely eat. However, the dependency tool showed the provider had calculated they required less staff time allocated. Two other people's assessed needs for the length of staff time to meet their needs had increased significantly between two assessments. The provider told us there had been no change to these people's needs other than people getting older. This evidenced that the provider's assessment tool was not reliable in assessing staffing levels.

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.

● The provider had not always followed safe recruitment procedures to ensure that staff employed to work with people were suitable for their roles. We reviewed two recruitment files for staff who had been employed since the last inspection.
● Both staff application forms had gaps in the employment history that had not been accounted for. Interview records did not evidence that this had been identified and discussed. References had not been obtained from the previous employer of one staff member.
● Records showed staff had not always received Disclosure and Barring Service (DBS) clearance before they started work. There was a gap of three months between one staff member starting and their DBS check. 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 told us the staff member had not worked during the three-month period. However, staff rotas evidenced the staff member had worked for the full period including on occasions when they were unsupervised.
● The provider and registered manager could not be assured the staff they had employed were suitable to work with people living at the service. Unsafe recruitment practice had put people at risk of harm.

The failure to ensure staff were recruited safely is a breach of Regulation 19 (Fit and proper persons employed) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Medicines administration records (MAR) showed most people had received their medicines as prescribed. MAR are important records which document when people are given medicines. However, there was no MAR in place for one person's Paracetamol, yet stock records showed they were given two Paracetamol on one date. The provider had failed to follow their medicines policy because medicines had been administered which had not been recorded on a medicines administration record.
● One person needed prescribed laxative medicine given regularly to maintain bowel function and to avoid constipation. Constipation would affect their health condition and cause them pain and discomfort. MAR showed the person had been administered their laxative once in 19 days. There was no evidence that this was discussed with the person's GP or medical advice sought about how this would impact on their health. Records showed the person had not opened their bowels on three consecutive days and a further two days in a seven-day period. The risk to this person from constipation had not been reduced through administration of laxatives or seeking medical advice.
● Medicines were not always kept at the correct temperatures to maintain their efficiency. In July and August 2020 the temperature was recorded at or above the maximum temperature of 25 degrees Celsius on 36 days. Whilst the fan in the room had been put on as an action, this action was insufficient to reduce the temperature. The operations manager told us they had purchased air conditioning units for the service, but

these were for communal areas. Storing medicines outside of the manufacturers recommended range for a long period of time may affect the efficacy of that medicine.
● Protocols were in place for most people to detail how they communicated pain, why they needed as and when required medicines and what the maximum dosages were. However, some people did not have PRN protocols in place. One person had PRN Paracetamol in stock which conflicted with other information which stated they were not currently on PRN medicines. Another person had no PRN protocol for co-codamol. This meant that staff (including those administering these medicines) may not have all the information they need about people's PRN medicines.
● The provider's policy in relation to disposal of medicines stated that dropped/damaged doses of medication, should be disposed of via a licensed waste handling company. On 6 August 2020 one person's Ferrous Sulphate was accidently dropped and stood on causing it to be crushed. A staff member told us they had placed the dropped tablet in the rubbish bin in the medicines storage room as it was completely destroyed. This was not safe practice.

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

Preventing and controlling infection

At our last inspection, the provider had failed to ensure the service was clean and properly maintained. 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, improvements had been made in some areas, the provider was no longer in breach of regulation 15 with regards to the cleanliness of the service. However, there were still areas of concern.

● At our previous inspection, there had been an underlying odour present in some areas, even though the provider said they were cleaning the carpet regularly. At this inspection, this remained the same in two areas of the service.
● Since the last inspection the provider had employed a cleaner to carry out cleaning duties five days a week. Most areas of the service looked cleaner. However, some areas looked not in good repair and not always clean. Where areas of the service had been poorly maintained this would impact the ability to clean some surfaces and areas.
● Some communal areas did not look completely clean. A bathroom had a build-up of limescale in in the bath. Where flooring was damaged it could not be effectively cleaned. Cleaning schedules had not always been completed to show daily cleaning had taken place in communal areas, so it was unclear how often cleaning was carried out. Records the provider gave us for 20 July, 27 July, 4 August and 5 August 2020 showed that toilets had not been cleaned on any of the days, the sluice room had been cleaned once, corridors had been cleaned twice. The records also showed that dispensers had not been cleaned at all. It was unclear how often communal cleaning had been carried out.
● The provider's COVID-19 risk assessment had not identified that additional cleaning and sanitisation should take place following people and their relatives meeting in the garden at the table and chairs. We observed the table and chairs were dirty and dusty despite relatives visiting their loved ones whilst we inspected.

We recommend that the provider considers current guidance on cleaning and infection control to update their practice accordingly.

● Additional cleaning took place within the service to decrease risks of contracting and transmission of COVID-19. We observed staff cleaning door handles, tables, chair arms and other areas of the service which people are likely to touch more frequently.
● People living at the service and staff had each received a COVID-19 test. The provider told us that they had registered to receive regular whole home testing for people and staff.

Systems and processes to safeguard people from the risk of abuse

● The provider continued to report any concerns to the appropriate authorities. No concerns had been reported since the last inspection.
● Staff had confidence in the management team and provider to appropriately deal with concerns. One staff member said, "I would report it to the manager. I could report it to CQC. The manager would deal with it."
● Relatives told us their loved ones were safe. One relative said, "They kept COVID out and other care homes didn't. Staff didn't socialise or anything to safeguard people."

Inadequate

# Is the service effective?

## Our findings

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

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

At our last inspection, the provider had failed to make sure staff had received the training and development to meet people's needs. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, although some improvements had been made, the provider continued to be in breach of regulation 18.

- Although some staff had completed training courses, there continued to be areas where some staff had not been trained. New staff (one of whom had been employed since March 2020 and one who started in June 2020) had not undertaken training considered by the provider to be essential for staff to keep themselves and people safe. Both new members of staff had not undertaken health and safety, food hygiene, first aid and COVID-19 specific PPE training.
- Only one staff member had undertaken fire marshal training and they worked Monday to Friday. The provider had not put in place fire marshal training for other staff who would be responsible for running the shifts during the evenings, at night and at weekends. Given that fire risks were increased at the service due to non-working fire doors this posed a risk to people living in the service.
- Cooking tasks were completed by the housekeeper, the operations manager or the provider when the cook was not working. The provider had not attended food hygiene and safety training since 2002, the operations manager had not attended food hygiene and safety training since 2015 and the housekeeper had not attended the training at all. None of the staff with responsibility for cooking had completed food allergens training. The Food Standards Agency specifies that 'business operators must ensure that food handlers receive the appropriate supervision and training in food hygiene' and 'must make sure that staff are trained to manage allergens.'
- At the last inspection we reported that the provider had completed training in how to deliver training to staff. However, they had not updated any of their own mandatory training. At this inspection the provider had updated some of their own mandatory training. They had completed, fire awareness, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS), care planning and COVID-19 specific PPE training. They had not updated and completed any other mandatory training. This meant the training and supervision they provided to staff continued to not include the most up to date guidance and best practice.

The failure to ensure staff had the appropriate training to ensure people's needs were met is a continued

breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff continued to be supported in their role through one to one supervision sessions with a member of the management team. Staff told us they felt well supported by the registered manager. One member of staff told us, "I think I'm alright with supervision, I have my team leader and I meet with [the provider] or [operations manager]. They have told me they are available at any time." Another staff member said, "I had a one to one last week."
● People and relatives gave us positive feedback about the staff. One relative said, "The carers are great, I know them very well now." Another relative told us, "Staff are very friendly, they love mum." People said, "They are very good girls that work here. I don't have any trouble. They are kind girls, they are kind to all of us" and "All staff are helpful."

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

At our last inspection, the provider had failed to ensure the premises were suitable for the purpose it was being used. Concerns included, the need to update the premises, bedrooms were bare and impersonal, dementia friendly signage and lack of adequate smoking facilities for people using the service. This was a continued breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, some improvements had been made, however there were still areas of concern. The provider continued to be in breach of regulation 15.

● The environment remained almost unchanged from the last inspection. The service continued to need updating to provide a better maintained and better presented environment for people to live in. The provider told us one person's room had been decorated since the last inspection. There remained plans in place to redecorate the service and fix areas that had been damaged since we last inspected following a water leak; and work to replace doors. The signage the provider had previously purchased had not yet been put on display. This meant that communal areas were still not dementia friendly and further work had not been carried out to the layout, décor and flooring.
● One person's window blind had broken in their bedroom on the first day of the inspection. The provider told us it had broken three days before. They told us that a new blind had been purchased and this was in the office. We checked with the operations manager on the second day of the inspection whether the blind had been replaced. The operations manager told us that evening that the blind was not repairable and a new one was being purchased over the following few days. They told us a curtain had been placed over the window on 7 August 2020 as a temporary measure. The person had no window covering on the window for at least four days.
● Some maintenance and servicing had been completed by contractors. For example, gas safety, electrical safety and legionella. The passenger lift and one person's bed had been checked. However, other equipment such as hoists, bath chairs and another bed had not been checked. The provider told us that the hoists and bath chairs had not been serviced in line with the correct timescales because of the pressures of COVID-19. However, they had not risk assessed this or considered other suitable ways of enabling the contractor to service the mobile equipment without putting people at risk. We highlighted this to the provider during the first day of the inspection, and they arranged for this to be completed, this was scheduled for 13 August 2020.
● The emergency lighting system had been serviced and checked on 19 June 2020. Eight lights needed action and the contractor had recommended changing the lights for LED ones, and reported a concern that

there was no outside emergency lighting. Work to rectify these issues had not been arranged. The operations manager contacted the contractor when we raised this and arranged for the emergency lights to be repaired on 10 August 2020.
● One person's hospital style bed and air flow mattress had not been serviced or checked since 5 November 2018. The provider told us that the bed was checked to ensure it was working correctly regularly but there were no records in place to evidence this.
● The smoking area for people was on the patio and had not yet had a covered area installed to protect people from poor weather. The operations manager told us staff supported people to go out the rear door to the patio area when the weather was too hot because the conservatory was locked off to prevent people from entering it and to prevent the heat from the conservatory to enter the home. The pathway leading from the rear door to the patio area was partially blocked by a single mattress, which restricted the width of the pathway and could be a hazard to people with deteriorating mobility.
● The provider had not considered enabling the person's relatives to drop off items without entering the service; which would have supported them to create a homely, relaxing, personal environment. The provider told inspectors they did not think the person had any personal items. Bedding remained the same as the last inspection. It was faded and sets of bedding did not match.

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

● The provider told us they had purchased new carpet for two rooms however these had not yet been fitted because of COVID-19.
● Relatives told us, "I know the building is shabby, but it is about the care and [loved one] has always been happy." A person told us, "It's lovely here, it's really nice. This home is a very large house, the rooms are beautiful."

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

At our last inspection, the provider had failed to make sure people's rights were upheld within the principles of the MCA. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found there had been very little improvement made to assessing people's capacity and making sure decisions were made in their best interest. The provider was still in breach of regulation 11.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being

met.

● People's care plans contained conflicting and confusing information about their mental capacity. One person had a number of assessments which were contradictory about their capacity. Where it was deemed that action should be taken in their best interest, there was no evidence to support that the decision had been made in line with MCA 2005 Code of Practice and that the persons' rights had been properly considered.
● Where people had a DoLS authorisation, care plans did not provide clear guidance to staff. This meant staff may not have the information they needed to understand people's legal status and make sure their rights were upheld.
● Some relatives had lasting power of attorney (LPA) to help people with their decision making about specific areas when they lacked capacity. Two people's relatives had been involved in decisions about COVID testing when their LPA authority did not cover this health-related decision. This meant people's rights and choices were not protected in line with the MCA 2005.
● The provider had reviewed and updated one person's capacity assessments since the last inspection, and these were improved. However, a best interests decision document did not show who had been consulted with to make the decisions and whether any least restrictive options were available.
● One person had a DoLS authorisation with a condition that the service should explore activities the person could do in their room. Examples of activities such as playing cards, completing puzzles, listening to music or encouragement to sit up and watch television had been suggested by the local authority. They also suggested these areas were explored further with the mental health team involved in the person's care. The person's activities care plan and review records did not mention the DoLS condition and how the service planned to meet this. Daily records did not refer to encouragement with activities or show that activities had been offered and/or declined. The only record of the person engaging with watching television was that it was put on whilst they were eating their meals. This meant that the person did not have suitable stimulation to keep to maintain good mental health in line with their DoLS condition.

The failure to ensure people's rights were upheld within the basic principles of the Mental Capacity Act 2005 is a continued breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had correctly applied for DoLS within the MCA for some people living at the service and had monitored when these were due for renewal.

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

● At the last inspection the provider had developed more detailed care plans. At this inspection some people's needs had changed but care plans had not been reviewed and updated to reflect this. One person's care plan stated they were independent with eating and were type 2 diabetic, controlled with tablets. However, their needs had changed, and they were now type 1 diabetic and required staff assistance to cut up their food and eat. Whilst we observed staff supporting the person with their meals to evidence they were meeting the person's new needs, the failure to record the change in needs put the person at risk if new staff or temporary staff worked with them.
● Recognised tools were used to assess people's nutritional needs and skin integrity. However, these had not always been correctly used. One person's weight had changed and there had been changes to their health. These had not been identified during the monthly review of the assessment and the risk scoring had remained unchanged. This meant the person was at an increased risk of developing pressure areas, but their records did not alert staff to this. Another person had previously been under the care of a dietician and had

been discharged in November 2019. The discharge letter stated, 'please re-refer if further dietary advice needed.' Records evidenced that the provider had not referred them back to the dietician when the person had lost 11.2kgs in weight in three months, there were no records to show that the provider had discussed this with the GP. The provider showed us communication on the 11 August 2020 to evidence that they had told the GP the person had lost some weight.
● Care plans about people's mouth care detailed that people required help and support to clean their teeth once a day in the morning, and this was not repeated in their evening routine care plan. Assessment had not been completed to show how many times a day people needed support or encouragement to clean their teeth which created the opportunity for this to happen just once daily. A relative told us they were concerned about their loved one's oral hygiene as they had noticed the decline in their teeth.

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

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

● Paramedics had attended the service to meet people's medical needs when required. Records showed that the service had maintained contact with the GP. Medicines reviews had also taken place. One person told us, "I get pain relief when I want and I can see the GP."
● During the COVID-19 pandemic community nurses continued to visit the service to meet people's nursing needs. A chiropodist had visited the service during the pandemic to meet people's needs. The chiropodist was contacted during the inspection to book another appointment as staff had identified people required toe nail care again.

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

At our last inspection, the provider failed to ensure risks to people's health were identified and managed to prevent harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, some improvements had been made. The provider was no longer in breach of regulation 12 in relation to monitoring nutrition and hydration risks.

● Records relating to food and fluid intake were clear and consistent. People were encouraged to drink plenty and fluid intake was monitored and recorded. Extra measures were taken to ensure people stayed hydrated in the hot weather, staff supported people to have ice lollies to keep them cool and hydrated.
● Meals and drinks were prepared to meet people's preferences and dietary needs. People continued to have choices of meals. The cook and staff continued to be aware of people's likes and dislikes and the special diets or food consistencies some people were advised to have.
● People had their meals in the dining room, lounge or in their bedrooms. Where people had left food, staff checked that they had finished and asked if they had eaten enough and if they wanted anything else. People told us they had choices of meals that met their needs. Comments included, "It was very nice"; "Very tasty"; "Very nice food" and "Today I have chosen a jacket potato and cheese for lunch."

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 now remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At our last inspection the provider had failed to ensure a robust approach to 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.

At this inspection, enough improvement had not been made and the provider was still in breach of regulation 17.

● The provider had a monitoring system in place to check quality and safety, however, this continued to not be effective. Despite multiple failings being highlighted to the provider following our last inspection, we continued to find that people were at risk of harm. This was because risks to them were not always recognised by the provider, or where risks were identified not enough was done to minimise them to keep people safe. There was no action plan to support the monitoring and progress of work to remedy the issues we had found at the last eight inspections. Not enough improvements had been made to identify the continued concerns and to show good quality and safety could be made and sustained. This meant, although improvements had been made in a few areas following the last inspection, many areas had not improved. Where previous inspections had found areas of compliance with regulations such as medicines management and safe recruitment practice, we found that these improvements had not been sustained and had declined. which put people at risk.
● Where the provider's audits and checks had identified areas of concern, action plans and follow up work had not been carried out to assess the risks and mitigate these. For example, the registered manager's audit for June 2020 identified that hoists and moving and handling equipment had not been serviced and maintained in line with legislation, however action had not been taken to follow this up with the contractor. The May 2020 registered manager's audit identified that cleaning schedules had not been completed, rather than ensuring the cleaning was completed and schedules then filled in, the provider had recorded 'this will not be rectified until the new domestic is in post.' The new housekeeper did not start work until 22 June 2020.
● At the last inspection we reported a lack of planning which had impacted on the provider's response to serious fire safety concerns, leaving people in a potentially unsafe environment without risks being assessed and managed. At this inspection, we found a similar issue; the provider had not put adequate plans in place to manage people's safety in the event of a fire because essential works had not been completed. Although

the provider told us they had not been able to progress the works due to COVID-19, they had not assessed the increased risk during this period and had added to the risk by propping fire doors open. The provider's fire checks recorded that fire exits were clear. We observed that vacuum cleaners were stored in one fire escape and spoke to the provider about it. They told us that the vacuum cleaners were always stored there.

● At the last inspection we found the lack of planning around consistent and effective cleaning had a detrimental effect on the service. Actions had not been taken in response to cleaning schedules not being completed. At this inspection, cleaning schedules had been partially completed, however communal areas were regularly missed off the schedules, so there was no record of them being cleaned. During the COVID-19 pandemic, attention to hygiene and infection control is especially important. There had been no effective oversight of staff practice in relation to wearing appropriate face coverings. The provider's infection control audits had not identified this.

● Medicines audits were not robust. The medicines audit undertaken on 27 July 2020 had failed to identify that some people did not have as and when required (PRN) medicines protocols in place and had not identified that some prescribed medicines were not listed on the medicines administration records. The audit had also failed to check whether medicines were being stored at the correct temperatures. The audit had not identified that one person had frequently declined their medicine, which they were prescribed to manage a health condition. This meant an opportunity to discuss this with the person's GP had been missed.

● Staffing audits were not robust. The staffing audit dated 29 July 2020 had identified some areas of improvement, the actions had not yet been completed. The audit had not identified the concerns in relation to staff working before Disclosure and Barring Service (DBS) clearance was received.

● At the last inspection we reported that people's care plans were not always accurate and were repetitive with the result of being very long. The last inspection identified that staff spent a lot of their time completing daily records. The provider agreed staff were spending their time writing rather than with people but had not considered solutions to this. At this inspection, we found again that care plans were not always accurate and large sections of information were repeated which made them difficult to read. There was a lack of oversight in relation to care plans when people's health had changed or declined or where accidents and incidents had occurred. This meant the opportunity to amend and embed changes in to people's care plans and risk assessments had been missed. The review sheet of a care plan often recorded that something had changed for the person, however the changes were then not made into the care plan which meant that care plans contained out of date or conflicting information. This created an opportunity for staff to follow the wrong guidance about people's care needs.

● Oral health care had not been considered within the provider's audits, therefore they had not identified that the care plans in place listed that support to manage people's oral health was only being completed once a day. This does not follow the National Institute for Health and Care Excellence (NICE) guidance for improving oral health for adults in care homes. People should be supported to brush their teeth at least twice a day.

● The provider's health and safety audits had failed to identify that essential tasks had not consistently been undertaken on a monthly basis. For example, water temperatures had not been checked and recorded in June 2020.This meant that the provider could not be sure that water was not too hot for people using the service.

● The provider was not following the Health and Safety Executive's (HSE) guidance in managing legionella in hot and cold-water systems. The health and safety and infection control audits undertaken by the provider has not identified this. The HSE guidance specifies that empty rooms and areas of low usage should be flushed out at least weekly and shower heads should be cleaned out at least quarterly. The provider had only completed flushing of empty rooms four times since we last inspected in February 2020. The shower heads had not been cleaned since 21 April 2020. This demonstrated that potential risks were not being well-managed.

● At the last inspection the provider, who was also the registered manager, and therefore legally responsible for the running of the service, was not on the staffing rota as part of the management team, they were assigned as the cleaner. At this inspection they were now listed on the staffing rota as a manager. A separate housekeeper had been employed. They now had dedicated time on the rota to run and manage the service. However, the continuing areas of concern found during this inspection, identified that the provider had not effectively managed the service.

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

● Some audits were effectively monitoring people's safety. For example, audits which checked and analysed accidents and incidents, by identifying themes and taking action where needed. These showed that where people had a number of falls, they had been referred to a relevant healthcare professional.
● The registered manager's walkaround audit had identified some areas and actions had been taken. For example, one audit identified that some rooms required vacuuming and there had been an unpleasant smell in some areas, the audit showed that the areas had been cleaned.
● 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.

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

● Staff told us the provider and management team supported them well, were approachable and always available to listen to concerns.
● Staff said the whole staff worked well together as a team. One staff member said, "We have a good team, I love all the girls (staff)." Another staff member said, "I'm happy, I'm good, I like it."
● People told us, "[The provider] and [The operations manager] are the managers, I couldn't ask for nicer people"; "The lady in charge is very helpful."

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

● The provider had notified us of incidents relating to the service. These notifications tell us about any important events that had happened in the service.
● The provider had notified relatives of incidents relating to their loved ones. A relative told us they felt well informed and said, "The service is managed very well."
● No complaints or concerns had been received so we could not check if the provider now had effective processes to make sure they listened to concerns to improve outcomes for people.

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

● At the last inspection we found that surveys had not been undertaken over the last two years to gain feedback and make improvements based on feedback received. The operations manager told us at this inspection that no surveys had been undertaken and they planned to request feedback from people in

September 2020.

● At the previous inspection residents' meetings had taken place. However, there were no records of these. At this inspection, records had been made of meetings held. A meeting held on 29 June 2020 showed that 10 people had participated in a meeting. The provider had also engaged individually with three other people who had not attended to ensure their views and feedback had been captured. The meeting records showed that the COVID-19 pandemic had been discussed as well as arrangements for people to continue communication with their relatives by video calling or telephone and plans for future changes were also documented.

● Relatives meetings had not taken place because the service was closed to non-essential visitors. since the start of the COVID-19 pandemic. Relatives were enabled to visit their loved ones in the garden whilst social distancing.

● Records showed that staff meetings were held. The provider had not held as many meetings as usual due to the COVID-19 pandemic. The last meeting took place on 20 July 2020. The records showed that staff had the opportunity to raise concerns and to be involved in supporting the improvement of the service. The meeting records also showed staff were praised for their hard work and discussions had taken place to support staff mental health and wellbeing. One staff member told us, "They had a staff meeting in July, if I can't go to a meeting, they would show me the paperwork."

● Compliments had been received. One relative had commented, 'A big special thank you for the care and support you provide for [person] my mum. she loves you all.' Another relative had written, 'You are doing a fantastic job and we all appreciate it and you don't get enough praise for your work.'

Working in partnership with others

● Relatives confirmed that they had received regular contact from the management team. One relative said, "I talk to [the operations manager] a lot to keep up to date." One relative told us that communication had not always been good and gave an example of finding out from care staff that their loved one's health needs had changed, which the provider had not informed them about.

● The provider had not had the opportunity to attended local forums or national events to liaise with others and keep up to date with good practice.

● 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.

This section is primarily information for the provider

# Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider had failed to ensure people's rights were upheld within the basic principles of the Mental Capacity Act 2005.<br>Regulation 11 |

**The enforcement action we took:**

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider has failed to ensure risks were robustly identified and managed so that people received safe care. The provider has failed to take appropriate actions to ensure medicines are managed in a safe way. The provider has failed to monitor incidents to learn lessons and mitigate individual risks.<br>Regulation 12 |

**The enforcement action we took:**

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 15 HSCA RA Regulations 2014 Premises and equipment<br><br>The provider has failed to ensure the service was visibly clean and free from offensive odours. The provider has failed to ensure the premises is suitable for the purpose it is being used.<br>Regulation 15 |

**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<br><br>The provider has failed to ensure accurate records are kept to ensure people's care and support is safe and meets their needs. The provider has failed to make accurate records to ensure people's health was closely monitored to prevent harm. The provider has failed to ensure a robust approach to improving the quality and safety of the service.<br>Regulation 17 |

**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 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>The provider has failed to ensure staff were recruited safely in to the service by completing the appropriate checks.<br>Regulation 19 |

**The enforcement action we took:**

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider has failed to ensure staff were deployed so people's care needs and preferences were met. The provider has failed to ensure staff had the appropriate training to ensure people's needs were met.<br>Regulation 18 |

**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.