The Serenity Care Company Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: Serenity Care is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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 was a large home, bigger than most domestic style properties. However, despite the size of the property it was only registered for the support of up to 5 people. At the time of our inspection there were 3 people living in the home. Signs remained outside to indicate it was a care home however staff were discouraged from wearing anything that suggested they were care staff when coming and going with people.

The service also provides personal care to 50 people living in their own homes in Gainsborough and in Grantham.

The service had been developed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with a learning disability were supported to live as ordinary a life as any citizen.

People's experience of using this service:
There was not a system in place to carry out quality checks in either the residential setting or the homecare service.

Medicines were not consistently managed safely. Arrangements were not in place to store and manage medicines safely.

Risk assessments had not been completed for people living in the residential setting.

The outcomes for people using the service reflected the principles and values of Registering the Right Support in the following ways [promotion of choice and control, independence, inclusion] e.g. People's support focused on them having as many opportunities as possible for them to gain new skills and become more independent.

People said they felt safe. There was sufficient staff to support people.

People enjoyed the meals and their dietary needs had been catered for. Staff supported people to have a healthy diet.

Care plans for people living in the residential setting did not contain information about people and their care needs. Care plans for people receiving care in their own home were completed and included information to assist with the provision of personalised care.

Staff had received training to support their role. Staff had started to receive supervision and plans were in

place to ensure people received this on a regular basis.

People had good health care support from professionals. The provider and staff worked in partnership with health and care professionals.

Staff were aware of people's life history and preferences and they used this information to develop positive relationships and deliver person centred care. People felt well cared for by staff who treated them with respect and dignity.

People in the residential setting had access to a range of activities including participating in leisure pursuits in the local community.

The environment was not fully adapted to support people living with learning disability. A refurbishment plan was in place to address this.

The home was not clean in some areas and arrangements were not in place to manage the risk of cross infection.

The provider had displayed the latest rating on the website. When required notifications had been completed to inform us of events and incidents.

More information is in the detailed findings below.

Rating at last inspection: Requires Improvement (Report Published). At our previous comprehensive inspection in October 2017 the service was rated overall requires improvement. We found a breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010.

At this inspection we found a continuous breach of Regulation 17 and a breach of Regulation 12.

We have taken this into account in determining the rating.

Why we inspected: This inspection was a planned inspection based on the previous rating.

Follow up: We will ask the provider for an action plan to indicate when they will have consistently addressed all the issues. Please see the 'action we have asked the provider to take' section at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe	**Requires Improvement**
Is the service effective? The service was not always effective	**Requires Improvement**
Is the service caring? The service was caring	**Good**
Is the service responsive? The service was not consistently responsive	**Requires Improvement**
Is the service well-led? The service was not well led.	**Inadequate**

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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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was carried out by two inspectors and an Expert by Experience. An Expert by Experience is a person who has had experience of the relevant care setting, in this instance experience of service for people living with a learning disability.

Service and service type:
The service had two managers registered with the Care Quality Commission. One registered manager was responsible for the domiciliary care service and the other for the residential service. 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 was a comprehensive inspection and was unannounced.

What we did:
Prior to the inspection we examined information we held about the service. This included notifications of incidents that the registered persons had sent us since our last inspection. These are events that happened in the service that the registered persons are required to tell us about.

The provider had completed a Provider Information Return. This is information we require providers to send

us at least once annually 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 three people who lived at the service, two members of care staff and the registered managers. We also spoke with five people who received care in their own home and looked at eight care records in detail and records that related to how the service was managed including staffing, training, medicines and quality assurance.

Requires Improvement

Is the service safe?

Our findings

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

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

At our last focused inspection in October 2017 we rated this question as requires improvement. This was because we identified concerns in relation to how medicines were managed. At this inspection we found the concerns in relation to the safe management of medicines were still present and this domain continues to be rated as requires improvement. We also found concerns relating to risk assessments not being in place and the lack of systems in place to manage infection control.

Using medicines safely

•At this inspection we found medicines were not consistently managed safely. Written guidance was not always in place to enable staff to safely administer medicines which were prescribed to be given as and when people required them, known as 'when required' (PRN). There was a risk people would not have access to medicines as prescribed.
•Regular medicines checks had not been carried out to ensure medicines were managed in the right way.
•Medicines were not stored safely. The medicine trolley was not secured to the wall and medicines requiring additional security, were not stored safely and according to national guidance. We found a person's medicines had been left on the office desk. The room was unlocked and during the inspection we observed people could access the office unsupervised. There was a risk people could come to harm because they would be able to access medicines without supervision.
•Medicine administration records (MAR) clearly stated if the person had any allergies. This reduced the chance of someone receiving a medicine they were allergic to.
•Staff told us they had received training about medicines and had been observed when administering medicines to ensure they had the correct skills.

Assessing risk, safety monitoring and management

•We found that risks to people's safety had not been consistently assessed. Risk assessments had been completed for people who received support in their own home. However, risk assessments had not been completed for those people who were living in the residential setting. We saw there were a number of identified risks detailed on admission documentation but these had not been addressed as part of a formal risk assessment and plan of care to mitigate the risk. For example, there was a risk of people causing harm to themselves as a result of their behaviour, or by accessing the community and using equipment such as knives and garden tools. One person who had previously attempted suicide on two occasions did not have risk assessments in place. Risk assessments are important to ensure people are supported appropriately to prevent the risk of harm.

The above demonstrates a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

•People's needs had been assessed and their care given in a way that suited their needs, without placing unnecessary restrictions on them.

Preventing and controlling infection

•We observed suitable measures were not in place for managing hospital acquired infections.
•There were areas in the home which had not been sufficiently cleaned to minimise the risk of cross infection. We saw in the quiet area there was evidence of food being spilt below a table which required cleaning up. The kitchen floor was sticky and required cleaning.
•The laundry area did not have defined clean and dirty areas. We observed clothes were left on the floor waiting to be washed and piled on top of the washing machine. There was a risk of cross infection.
•Washing chemicals were stored in the laundry and the door to the laundry area was not locked or closed. The area was accessible to both staff and people who lived at the home which presented a risk to people.

Learning lessons when things go wrong

•Records showed that arrangements were not consistently in place to record accidents and near misses, and arrangement to analyse these so that the home manager could establish how and why they had occurred, were also not in place. We observed a medicine error had occurred and the documentation was not fully completed. There were no details of the outcome of the incident or subsequent actions such as review of the person's care plan or risk assessment to prevent a similar issue occurring again. We spoke with the registered manager who was unable to provide the paperwork.

Systems and processes to safeguard people from the risk of abuse

• People told us they felt safe living at the home. One person told us, "Yes, Staff are nice." Another said, "Yes, lot of support staff."
•We spoke with staff about the protection of vulnerable people. Staff knew the procedures to follow and where to access information if they suspected bad practise or observed altercations with people who used the service. They told us they had received safeguarding training. Records showed that care staff had completed training.
•Where incidents had occurred the registered managers and staff had followed local safeguarding processes and notified us of the action they had taken. Staff told us they thought people were treated with kindness and they had not seen anyone being placed at risk of harm.

Staffing and recruitment

•There were sufficient staff available to meet the needs of people. The home manager had recently recruited to vacant posts to ensure continuity. Staff told us they thought there were sufficient staff to keep people safe.
•The registered persons had undertaken the necessary employment checks for new staff. These measures are important to establish the previous good conduct of the applicants and to ensure that they were suitable people to be employed in the service. The registered persons had carried out checks with the Disclosure and Barring Service to show that the applicants did not have relevant criminal convictions and had not been guilty of professional misconduct.
•People who received support in their own homes told us there were sufficient staff and they had time to

respond to meet their needs. One person said, "[Service or staff] would respond to any request, quite good."

Requires Improvement

Is the service effective?

Our findings

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

The service did not always apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.

The effectiveness of people's care, treatment and support was inconsistent.

At our last focused inspection in October 2017 we rated this question as requires improvement. This was because we identified concerns in relation to implementation of the Mental Capacity Act. At this inspection we found there remained concerns in relation to the implementation of the Mental Capacity Act and Deprivation of Liberty Safeguards(DOLS). This domain continues to be rated as requires improvement.

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

•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 with appropriate legal authority. 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, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met
•People's capacity to make day to day to day decisions had not been assessed and documented to ensure they received appropriate support. We saw there were a number of restrictions applied to people living at the residential home however, assessments had not been carried out to ensure these restrictions were in people's best interests.
•Applications for DOLs assessments had not been made and there was a risk people were being detained without legal authority.
•We found that arrangements had been made to obtain consent to care and treatment in line with legislation and guidance. Staff supported people to make decisions for themselves whenever possible. When people lacked mental capacity to make specific decisions a decision in people's best interests had not been put in place.

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

•The building was partially modernized with a large amount of planned work to offer a separate day service

and additional accommodation for people to live more independently. In this way the provider felt that they would offer a pathway to independence for those who are able. However, consequently there were areas which were accessible to people but presented hazards. The registered manager told us there were plans to refurbish this area this year and until this time would make arrangements to ensure the area was not accessible.
•The home had previously provided care to older people and we observed some areas which were currently in use such as a bathroom, had not been refurbished to meet the needs of the people living there but remained more appropriate to older people.
•Where people required specific equipment or adaptations to assist them with their care this was in place.
•People's rooms were personalised.
•We saw the outside areas needed tidying and repair, for example the garden area. However, the registered manager told us that this was included as part of the planned alterations to the building.

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

•Care plans were not consistently completed or reviewed. The format of care records for people in the residential setting had been reviewed to provide an improved format making information more accessible for staff. However, none of the three people living at the home had completed care records. This is important to ensure staff are aware of people's needs and wishes. There was a risk people would receive inappropriate care due to staff not being fully aware of their care needs. This was particularly an issue because the home had recently employed new staff.
•Care plans for people who received care in their own homes were in place and reflected people's needs.
•People who received residential care had not been involved in putting together care plans. The registered manager told us this was a cause of distress for some of the people and they were in discussions with social workers to agree a way forward. In the meantime, the service had copies of assessments previously carried out by the local authority prior to people's admission. There was a risk that people's needs were not fully assessed and they would not receive care appropriate to their needs.
•People who received care in their own home told us they had been involved in discussions about their needs and were aware of their care plans. One relative told us, "Yes, took part in the initial meeting and work with the Social Worker."

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

•We observed lunchtime. Staff were familiar with people's needs and likes and dislikes. We saw people were supported to choose what they wanted to eat and to prepare it.
•A choice of meals was available to people. Where people required support with meals in their own home this was detailed in the care records.
•We observed people had access to drinks throughout the day and if people asked for additional drinks or snacks these were provided. This helps to ensure people receive the appropriate hydration and nutrition.
•Staff working with other agencies to provide consistent, effective, timely care
•We saw from looking at people's care records that there was evidence that all the people who lived at the service had access to health professionals, to ensure that their on-going health and well-being.
•The registered manager was in regular contact with relevant professionals such as social workers to assist them with supporting people.
•Arrangements were not in place to support people who needed emergency hospital treatment. Care records did not include health passports or transfer sheets. These are important in the event of a person requiring hospital admission as they contain information which is important to the provision of care to people.

Supporting people to live healthier lives, access healthcare services and support

•Records confirmed that people had received the help they needed to see their doctor and other healthcare professionals such as specialist nurses, dentists, opticians and dieticians to ensure their health and welfare needs were met. One person told us, "Staff help me with all appointments."
•Where people had specific health needs for example diabetes these were detailed in care records of people who received care in their own home and in initial assessments for people who received residential care.

Staff support: induction, training, skills and experience

•Staff had had access to regular updates on issues such as first aid and moving and handling to ensure their skills were up to date to provide effective and safe care.
•Staff we spoke with were knowledgeable about their roles and responsibilities for caring and supporting people who lived at the home. They told us they felt they had the skills for providing care to people. A relative told us, ""Yes, Staff are very capable"
•Supervision had started to be in place. These are important because they provide staff with the opportunity to review their performance and training needs. We saw these had commenced and a programme to ensure staff received these regularly was in place.
•An induction process was in place and this was in line with the National Care Certificate for new staff. The National Care Certificate sets out common induction standards for social care staff and provides a framework to train staff to an acceptable standard.
•A relative told us they thought staff knew what they were doing and had their best interests at heart.

Good

Is the service caring?

Our findings

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

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity

•On the day of inspection there were three people attending the home for day care. This meant that people who lived at the home had to share their home with other people receiving support. This is disruptive for people living at the home and is not reflective of a homely environment. We saw there were plans in place to separate the environment however currently this was not possible.

We recommend the provider considers the principles and values of Registering the Right Support and other best practice guidance in relation to this arrangement.

•People told us staff were kind to them. A relative of a person who received care in their own home stated, "Very satisfied, [relative] did need more time with visits, now satisfied." Another person said, "Satisfied carers very nice."
•We observed staff interacting positively with people who used the service throughout our inspection. They gave each person appropriate care and respect while considering what they wanted. We saw staff enabled them to be as independent as possible while providing support and assistance where required.
•We noted that staff understood the importance of promoting equality and diversity and people were treated as individuals when care was being provided. Furthermore, the provider recognised the importance of appropriately supporting people if they identified as gay, lesbian, bisexual and transgender.
•We saw there was a relaxed atmosphere in the home and staff chatted with people in a kind manner. For example, at lunchtime a member of staff sat with a person to eat their lunch with them. We observed the member of staff continued a friendly conversation with the person while eating his own lunch.

Supporting people to express their views and be involved in making decisions about their care

•We found that people had been supported to express their views and be involved in making decisions about their care and treatment as far as possible. For example, a care record explained a person liked to have a bath every other day and detailed what support they required to achieve this. A person told us, "Yes, nothing I have asked for they have not been able to sort out so far."
•Where people were unable to communicate verbally arrangements had been put in place to support them. For example, we observed staff take time to adapt their communication for the people in a way that helped each individual, demonstrating staff knowledge of the people they were working with.
•People were asked if they required support before staff provided it. Records reflected the need to ensure people were happy with being supported.
•We saw where people did not have family or friends to assist them with making decisions contact had been

made with an independent advocacy service.

Respecting and promoting people's privacy, dignity and independence

•We found that suitable arrangements had not been maintained to ensure that private information was kept confidential. We observed when accessing information on the computer the screens did not lock after use to prevent people who did not have passwords accessing them.
•We found people's dignity was consistently respected. For example, people were called by their preferred names.

Requires Improvement

Is the service responsive?

Our findings

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

People's needs were not documented to ensure people's needs were consistently met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

•Where people received support in their own homes we saw care plans were in place. The assessments outlined what people could do on their own and when they needed assistance. They also gave guidance to staff about how the risks to people should be managed. They included areas such as; supporting people with their personal care, eating and drinking, keeping the person healthy and safe, supporting the person with activities and their likes and dislikes. These plans were person centred and set out people's individual preferences.
•However, we looked at care plans for people living at the home and saw people's files did not include assessments of their care and support needs or a plan of care. This meant it was difficult for staff to ensure they were providing care according to people's needs and wishes. This was particularly important as there were a number of new staff expected to commence employment in the forthcoming weeks and they would not be familiar with people.
•Where care plans were completed they were written in a user-friendly way in accordance with the Accessible Information Standard so that information was presented to people in an accessible manner. The Accessible Information Standard sets out the legal expectations to ensure people with a disability or sensory loss are given information they can understand, and the communication support they need.
•The registered manager told us their ethos of care was to promote independence so that if people wished they could move into a more community based setting.
•Whilst observing care in the residential setting we saw that people were given practical opportunities to make choices, with time to think or to change their minds.
•The staff knew people well and were respectful of their wishes and feelings. One person told us about activities and daily routines, "I like to decide on the day would get bored if I did the same thing every day like variety."
•People had access to a range of activities. One person told us, "Go shopping by car to Tesco to bring everything back, I have a bus pass for me, need to get one that lets me take a supporter with me. I enjoy the slide at the swimming pool, someone would go with me to Mansfield or cycle to the local pool" For example, on the day of our inspection one person was out shopping and another person had gone bowling. The registered manager told us activities were self-directed which meant people could choose what they wanted to do with the support of their one to one staff. A member of staff said, "Our aim is to make their life as full as possible."

Improving care quality in response to complaints or concerns

•There were arrangements to ensure that people's concerns and complaints were listened and responded to, to improve the quality of care. Complaints had been responded to appropriately and resolved.

•A policy for dealing with complaints was in place. We saw this needed updating as it did not reflect the current management arrangements in the home. This meant people and relatives would not be able to follow use the contact detailed in the policy.
•People told us they would know how to make a complaint if they needed to. One person told us, "Yes, no complaints, telephone if problems they explain if there has been any hold-ups." Details of how to make a complaint were available to people in the residential setting.

End of life care and support

•At the time of our inspection there were two people who required end of life care within their own home. The provider had arrangements in place to support people at the end of their life if required.

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

•At the previous inspection in October 2017 we found a breach of Regulation 17. Quality checks had not consistently addressed the issues found at this inspection. The systems in place to monitor the quality of care people received and to drive improvements were not adequate. At this inspection we found arrangements for checking the quality of the service had not improved and were not being carried out on a regular basis.
•Checks were not in place in either parts of the service. There was no system for checking the quality of care or analysing trends. For example, the registered manager for homecare told us they carried out observations but did not document this.
•In the residential area we saw areas such as infection control and medicines were not regularly checked. Arrangements were not in place to analyse incidents so that trends could be identified to avoid incidents occurring again.
•Records for people living in the residential setting, such as care plans and risk assessments were incomplete. This meant the service did not have an accurate, complete and contemporaneous record in respect of each person living at the home.
•An action plan had been developed in January 2019 with the local authority to ensure improvements were made prior to people coming to live at the home. We saw a few actions had not been completed, for example, some radiator covers were not fixed to the wall which meant there was a risk they could be used to cause injury to others and chemicals were not safely stored.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance.

•The previous inspection ratings poster was displayed on the provider's website.

Continuous learning and improving care

•The provider did not ensure national guidance was followed. For example, medicines were not managed according to national guidance.
•The provider did not work according to their policies. We checked the medicine management policy and saw it detailed the need for PRN protocols however these were not consistently in place. In addition, the provider was not storing medicines according to their policy.

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

•We found that people who lived in the service, their relatives and members of staff had not been engaged in the running of the service. For example, quality monitoring surveys had not been carried out.
•Staff meetings had not taken place since 26 April 2018. This was to inform staff about the proposed temporary closure of the home. However since the home had reopened there was no evidence of a recent staff meeting.
•Staff told us they felt supported. One member of staff told us, "Staff are a unit and respectful of each other." Arrangements were in place for staff to access a specific email where information and updates could be shared.

Working in partnership with others

•The service had liaised with the local authority to make improvements to the service. An action plan had been developed and we saw some actions had been completed. This was being monitored on a regular basis.
•Working relationships had been developed with other professionals to access advice and support. For example, the GP and local pharmacist.
•We saw a person presented with behaviour that challenged and a joint care plan with specialist mental health services had been put in place to support the person.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

•Records showed that the registered persons had correctly told us about significant events that had occurred in the service, such as accidents, incidents and injuries.

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 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed and stored safely. People living in the residential service had not had risk assessments completed. People were at risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a continuous breach of Regulation 17. The provider had failed to put in place systems and processes to monitor quality and improve care.