Phoenix Care Homes Limited

Phoenix House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Phoenix House provides accommodation and personal care for up to 24 people who need support with their mental health needs in one adapted building. There were 18 people living at the service at the time of the inspection. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

People's experience of using this service and what we found

The provider had failed to act to rectify shortfalls found at previous inspections. Lessons had not been learned and people continued to be at risk and were unable to live their lives in the way they wanted. People were not protected from the risk of harm. We found one person had numerous unexplained bruises which had not been investigated. Risks were identified but measures to reduce risk were not effectively re-assessed or implemented leaving people at risk of potential harm. One person had been given medicine to control their behaviour on numerous occasions without a valid reason. Some people were at risk of choking, but guidance had not been followed to reduce this risk. Peoples health needs were not always managed safely.

All people living at the service had been unnecessarily restricted up until the new manager had taken up post in August 2019. For example, the kitchen, toilets and bathrooms had been locked to prevent people from accessing them alone. 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. Health needs were not always supported well. Some people were diabetic but information to instruct staff in how to support them was lacking or missing. Processes to support people to eat safely and drink enough were not robust.

Whilst we observed some positive interaction between people and staff there remained a divide in the culture which did not demonstrate inclusion. People had not been supported to develop skills, set goals or achieve aspirations. Activities lacked personal meaning and people had not been encouraged to become more independent. People were not involved in their care planning and had not been given information in an accessible way.

There was poor accountability and oversight by the provider. The provider had failed to provide an inclusive, open or empowering environment for people and had not challenged the restrictive practice that people had been subjected to. The provider has failed to demonstrate how they have learned from previous inspections so the people receiving services were provided with safe care and support. People had not been fully involved or informed about the service.

Staff records showed that new staff were recruited safely. Staffing levels were enough to meet people's immediate needs. Staff had received training to support people although further improvement was required in this area. The complaints procedure was in an accessible format and included up to date, relevant

information of how people or other individuals could complain.

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

Rating at last inspection and update
The last rating for this service was Requires Improvement (published 19 October 2018). The provider completed an action plan after the last inspection to show what they would do and by when to improve. The service has been inspected five times since November 2015 and has continued to be rated either Requires Improvement or Inadequate. At this inspection not enough improvement had been made or sustained.

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

Enforcement
We have identified breaches in relation to Person-centre care, Dignity and respect, Safe care and treatment, Safeguarding service users from abuse and improper treatment, Good governance and Notification of other incidents at this inspection.

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.
If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Phoenix House

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by one inspector.

Service and service type
Phoenix House 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 did not have a manager registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided. There had been no registered manager in post since July 2019. The current manager had been in post since August 2019 and is currently applying to register.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority, professionals who work with the service and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. 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 five people about their experience of the care provided. We spoke to seven members of staff including the manager, deputy manager, care workers, and cook. We made observations of care to help us understand the experiences of people who chose not to talk with us.

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

After the inspection –
We continued to seek clarification from the provider to validate evidence found. The manager sent us some additional information after the inspection. This included staff training and supervision schedules, information around activities, audit information and minutes of meetings. We contacted three relatives about their experience of the care provided and received feedback from two.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires improvement. At this inspection this key question has now deteriorated to Inadequate.

Inadequate: This meant people were not safe and were at risk of avoidable harm.

At the last inspection on 05 and 12 September 2018 we found analysis of incidents in relation to action taken did not always contain as much detail as required and how staff were informed about the action taken required improvement. We identified not all new risks had been recognised or assessed specifically around people who wanted to self-administer their medicines although action was taken during the inspection.

At this inspection we found continued issues around how risks were assessed, and the action taken to reduce the risk of harm. We found concerns in how people were being protected from abuse, and how medicines were administered to support people with their behaviours.

Systems and processes to safeguard people from the risk of abuse

- People were not protected from the risk of harm. We found seven body maps of unexplained bruising relating to one person with no investigation as to how the person had been injured. The deputy manager and manager told us the person had been asked how bruising had occurred on occasions. However, there were no records of these conversations in any documents. Some of the body maps had been recorded before the manager had taken up post. Concerns had not been reported to any external bodies for investigation as would be expected. The manager made a referral to the local authority safeguarding team during our visit.
- The provider 's oversight of safeguarding concerns was not robust, and people were at risk of abuse. People living at the service had a variety of complex needs. A relative said, "My (loved one) has been assaulted a few times. They (the provider) did inform me and the police, I don't know what they can do apart from monitor." The manager said, "There is currently one open safeguarding. I do think (person) bullies those who don't fight back in my observation. We try to engage (person) in activities. It has been acknowledged that it's difficult to manage."
- Some people were prescribed as and when required medicine (PRN) to help them manage their behaviours and anxieties. We found poor practice around the administration of one person's PRN medicine.
- The person had been given medicine unnecessarily to control their behaviour which is a form of restraint. We found 12 different occasions between 25 September and 6 October 2019 when the person had been administered PRN medicine for managing their behaviour with no explanation as to why. On two days they had been administered PRN multiple times. No information was recorded on the back of the medication administer record (MAR) or in the persons daily records to describe the behaviours they were displaying which warranted the use of PRN. The deputy could not say why this had occurred, and they could not give an explanation.

The provider had not made sure people were protected from abuse and improper treatment. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Assessing risk, safety monitoring and management

● Risks were identified but measures to reduce risk were not effectively re-assessed or implemented leaving people at potential harm. Following a serious incident between two people in February 2019 a risk assessment had been implemented. This stated both people should be checked every 30 minutes, so staff knew of their whereabouts. The manager said they had stopped the 30 minute checks because they had not observed any concerns. However, the manager said they had not been made aware of all the previous concerns that had been highlighted during the inspection, which had not been investigated. This meant people were left at risk of harm. The measures to reduce the risk of harm to people had ceased without further re-assessment and one person had been found to have numerous unexplained bruising.

● Risks around the management of health was inconsistent. For example, one person was at risk of constipation. Although their care plan stated bowel monitoring charts should be completed, no bowel monitoring charts were in place and the person was unable to say if they were constipated. The persons care plan did not state when further medical intervention would be required if the person was constipated. We asked staff about the management of constipation and received a mixture of responses. Staff were not consistent about when they would support the person to receive further medical support or how they could recognise the person was constipated. Although this had not directly impacted the person, there was a risk should this happen in the future staff would not respond appropriately to support the person to remain well.

● Processes to support people to eat and drink enough were not robust. There was risk around people choking which was not well managed. Staff, including the manager gave us inconsistent information about who was on a specialised diet. The cook said, "Nobody has their food in a special way. No one is at risk of choking." However, this was not the case. The speech and language therapist (SALT) had recommended a 'soft and easy chew diet' for one person. The guidance specified that the person should not have bread. We reviewed their food diary and found on at least eight occasions the person had been given bread to eat including toast, sandwiches, garlic bread and pizza. The deputy manager said the person chose to eat this. There was no recorded information in the persons care plan to show they had been informed of the risks or additional risk measures implemented. Two people's fluids were being monitored but fluids were not always recorded, and fluid amounts were not always totalled. Care plan guidance contained no information as to what each person's recommended daily fluid aims were. There was a risk they would not drink enough fluid each day and could become dehydrated. When people had not drunk enough, action had not been taken to prevent this. Some of the monitoring charts recorded as little as 300ml drank in one day with no records of how this was followed up.

● Health needs were not always supported well. Some people were diabetic but information to instruct staff in how to support them was lacking or missing. The manager told us one person was diabetic but there was no diabetic care plan in place. Another person's care plan had no information for staff to refer to, so they could recognise the signs and symptoms if the person's blood sugar levels were too high. One staff member said, "I haven't come across someone's sugar levels becoming too high or too low, I think symptoms of too high or too low is shaking maybe. I haven't done diabetes training for a while, probably need to update it." Although this had not resulted in people being harmed this did not demonstrate people were supported well with their health needs and there was a risk they could be harmed in the future.

● One person was prescribed a cream which was highly flammable. This had not been included in their individual fire risk assessment and the person smoked. No measures had been thought about or implemented to reduce the risk that fire may pose. The manager said this should be incorporated into the persons fire risk assessment.

The above evidence demonstrates that the provider had failed to provide safe care and treatment. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Records, such as servicing and testing relating to the management of premises, including the safety of equipment, had been completed and were up to date. There were emergency action plans in place in the event of a fire and a contingency plan should the service be disrupted in an emergency situation. The manager had given responsibility to different staff to ensure safety checks were completed consistently.

Using medicines safely

● Stocks of medicines were correct, we noted that most medicines were in original boxes. There was no running total of how many tablets should remain. The deputy manager competed weekly audits on a selection of medicines. If any errors occurred for example, missing tablets or too many remaining tablets it would be difficult to identify when errors had been made. This is an area of improvement.

● Some people were prescribed creams to keep their skin healthy. Staff had guidance about where the cream should be applied and when, this was recorded on a MAR chart.

● Peoples medicine were kept in their own bedrooms in locked cupboards. Most people chose not to self-administer their medicines although they were asked frequently if they would like to be more independent with this. Some people went to specialist clinics for injections.

Learning lessons when things go wrong

● The service has been rated either requires improvement or inadequate at the previous five inspections. This does not demonstrate continued learning or embedding good practice which has been sustained.

● We have identified re-occurring concerns which we have previously reported on, the provider had not learnt or implemented measures to prevent repeated concerns.

● Risk had not been effectively re-assessed to prevent people from being harmed. For example, the risk assessment that had been established for the two people who had been involved in a safeguarding incident in February 2019.

● The manager said they had tasked one staff manager to analyse incidents. They would then inform the manager of what actions were needed. The unexplained bruising had been recorded but no action had been taken. This system had not been effective.

Preventing and controlling infection

● Most of the communal parts of the service were clean and smelled fresh. We did however, notice one corridor which smelled strongly of urine. The manager said they had cleaned the carpet once, but this needed to be cleaned again or the carpet replaced.

● Up until recently people had not been involved in keeping the service clean and tidy. The manager said they were trying to encourage people to become more involved.

● Staff had access to enough protective equipment and cleaning materials.

Staffing and recruitment

● Staff records showed that new staff were recruited safely. Relevant Disclosure and Barring checks were completed, references obtained from previous employers and employment histories checked. A risk assessment was put in place if any issues had been identified.

● Staffing levels were enough to meet people's immediate needs. The service was reliant on agency staff to ensure safe staffing levels. Care staff were supported by the manager and deputy manager during the week. The cook's role was currently being covered by a care staff. The manager said they was trying to find a permanent cook and a new staff member was currently going through pre-employment checks before starting work at the service.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement.

Requires Improvement: This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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 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.

- The manager said all people living at the service had been unnecessarily restricted up until they had taken up post in August 2019. For example, the kitchen, toilets and bathrooms had been locked to prevent people from accessing them alone. It was too early to see if this would be sustained and we had reported on restrictive practice at previous inspections.
- The manager said they had been reviewing mental capacity assessments and best interests' decisions as some did not seem relevant or appropriate. They had started to go through each person's care plans to identify restrictions so best interest decisions could be made. For example, restriction relating to cigarettes and finances.
- Some people were subject to a DoLS which had been authorised. Other DoLS had been applied for and were awaiting assessment. Nobody had any conditions attached to their DoLS at the time of our visit. Other people could make their own decisions.
- Staff knowledge around mental capacity was inconsistent. The manager said they had identified this and had put together information for staff to refer to which had been pinned to the board in the office.

One staff member said, "Yes almost all people have a DoLS in place not 100% sure. It's basically to assess if

they can have freedom to move around the service or stay here. I don't know of conditions off my head." Another staff member said, "I think everyone has a DoLS, I think some have conditions, I think some aren't allowed to deal with their own money or their own cigarettes and some aren't allowed out on their own." Another staff said, "DoLS, yes I would have to check who has and who has conditions."

● The manager had implemented a tracker to see when DoLS authorisations expired and recorded when new authorisations were applied for. They had introduced a DoLS summary which detailed any conditions and other information on one page to make it easier for staff to understand.

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

● The observations we made at lunch time did not demonstrate people were treated in an inclusive or respectful way. We have reported on this more in the Caring domain. A four weekly menu was implemented, and people were given alternative choices of food each day. One person told us they had enjoyed their lunch and they were able to choose what they wanted. Another person said, "The foods nice."

● People who were at risk of losing weight were monitored regularly and supported to increase their weight. Dietician and further advise from the GP was requested in a timely way.

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

● Although people were supported by a range of healthcare professionals, such as GPs, dieticians, psychiatrist and chiropodists, health was not always managed safely.

● Staff did not have good knowledge around specific health conditions people may have, for example constipation. The monitoring of health was not always robust. Care plans lacked information for staff to refer to, to help them support people with health conditions such as Diabetes.

● People did not have health care plans in place to support them to manage their mental health condition. Signs and symptoms people may display when there was a deterioration in their mental health were not known or recorded. This, combined with poor staff training in mental health placed people at risk of their health needs not being recognised or met.

The provider had failed to ensure people had health care plans in place. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff responded when people were unwell. During the inspection one person was supported to see their GP then attended the hospital as they were feeling unwell.

Staff support: induction, training, skills and experience

● Staff undertook online training in mental health awareness. However, the provider did not have a system in place to assess staff's competency or knowledge in supporting people with mental health needs following this training. Staff did not always demonstrate they had the right knowledge to support people with their individual needs. For example, we asked one staff member about the unnecessary restrictions placed on people. The staff member said, "Now the kitchen is open, now it's not locked there is freedom which is good. Before doors were locked. It was the older manager that put these rules in place, I thought before I had to do it because the manager told us to." The mental capacity and equality training some staff had received had not equipped them with the knowledge to be confident to challenge poor practice.

The manager said the induction form for new staff was due to be reviewed as it was sparse and needed to improve. New staff were assigned a senior to shadow for two weeks before working independently. Staff new to care completed The Care Certificate as part of their induction. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected in health and social care workers.

● Some staff had not received regular supervision or appraisals. This meant that staff did not receive feedback on their performance or have an opportunity to raise issues regarding the service or their

development.
● Staff did a mixture of online or face to face training. The majority of training was up to date in areas such as fire, infection control, emergency first aid, health and safety, challenging behaviour and mental health awareness. However, this training had not been effective: we found that people did not receive appropriate support with managing risks or their mental health. Competency checks on staff's understanding of their training and the effectiveness of it were only made around medicines.

The provider had failed to ensure staff were trained, competent and received support to carry out their role. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Two new people had recently been admitted to the service. The manager had completed an assessment before both people moved in. The pre-admission assessment document included all aspects of the person's needs including cultural, emotional and behaviours.
● The manager had started to review and update care plans. They used a dependency assessment which was reviewed each month which informed the rest of the care plan. There were assessments around falls, choking risk, and nutrition. The assessment had not captured details of people's mental health needs, or what support was needed regarding this.

Adapting service, design, decoration to meet people's needs
● The service provides accommodation for people on three levels. Floors could be accessed by a passenger lift. The manager showed us areas of the service which had been newly decorated, and areas that were planned to be improved in the future.
● Rooms were personalised and tailored to meet people's needs.
● There were accessible garden areas for people to enjoy.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement.

Requires improvement: This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- Whilst we observed some respectful and caring interactions between people and staff the culture within the service did not demonstrate inclusion. For example, at lunch time some people sat together in the dining area to eat their meal. Two staff stood by the table watching them eat. We asked the manager why staff did not join people and eat together, they told us the provider did not like staff eating with people.
- The manager said when they had started work at the service there were a lot of unnecessary restrictions placed on people. For example, the downstairs toilet and bathroom were locked because one person would use a lot of toilet paper and another person would frequently douse their hair with water. Other ways to support people had not been thought about so everyone's rights had been impacted on. The manager had only been at the service for a short time and it was too early to see if the changes would be sustained.
- Some people had religious beliefs and were supported to attend church. The manager said one person had religious beliefs but was not practicing currently and this decision was respected. Should the person choose to practice their religion later on this would be supported.

Respecting and promoting people's privacy, dignity and independence

- We found that opportunities for people to be rehabilitated and develop their skills were limited. Staff had not actively encourage people to get involved. The manager said when they had asked staff why people had not been involved in cleaning their own room or being more independent a staff member had said, "Oh no, I will get told off for not doing my duty properly."
- Staff had only started to encourage people to take part in the day to day running of the service. Staff did for people rather than with people. Staff did people's laundry, they tidied their rooms and they served people drinks without involving people. At lunch time we observed nobody was involved in helping make the meal which was served to them by staff.
- Nobody had planned goals or aspirations, they had not received the consistent approach they needed and had become de-skilled.

People were not always treated with dignity and respect. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- We observed some caring and respectful interactions between people and staff. For example, one person

was playing pool with a staff member. They talked together in a relaxed and humorous way and the person appeared conformable and at ease in their presence. When a person came to the office to ask the manager and deputy manager for help they responded immediately and in a patient way.

● One person frequently became agitated and distressed. Staff responded calmly and kindly. At lunch time the person became anxious, the deputy manager asked the person if they would prefer to eat their meal in their room. They spoke to the person gently and with concern. One person said, "Staff are all right, I'm treated well, I have my room how I like it."

● People had decorated their rooms in a personalised way. If they wanted to have a key to their bedroom they could, and staff respected people's choices. For example, some people did not want staff to go into their rooms so this was respected.

● There had been recent update of the environment. People had been involved in choosing colours of walls and the decoration. Staff asked people if they would like to talk to us. Some people declined, and this was respected. Other people who wanted to talk to us were asked if they wanted staff to be present, their choice around this was listened to.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Requires improvement. At this inspection this key question has remained the same.

Requires improvement: This meant people's needs were not always met.

At the last inspection on 05 and 12 September 2018 we found clear goals had not been identified to support people become more independent. Support to help people reach their full potential was lacking. Activity plans were required and more organised activities for people needed. Information was not in an easy read format to help people understand what was being said. At this inspection we found most of these concerns continued.

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

- People were not supported to be independent and had become de-skilled. People had not been supported to develop skills, set goals or achieve aspirations. One staff member said, "People don't really have goals or aspirations." One person had expressed a wish to enrol on a college course but had not been supported to pursue this. A staff member said, "Before people were taught French by a French lady, not now. There were rumours there were going to be college opportunities. People could do much more."
- The manager told us since August 2019 when they had begun to manage the service they had tried to change the approach staff took to support people with their independence. For example, people had not been encouraged to take ownership of cleaning their own rooms or do their own laundry. Although the manager had started to make changes and said people were happy they were more involved, further improvement was needed to support people to become more independent.
- One staff member said, "Residents are cleaning their rooms now, and being more independent. Before people couldn't just go in the kitchen to help themselves to drinks or make meals unless they were escorted. Now we are trying to encourage people to be more independent. I think a lot of people were de-skilled because of this."
- People's emotional needs were not consistently being met. The impact of people's mental health and their family's wellbeing had not been identified in people's care plans. The manager had started to update the care plans and said they were focusing on relationships and emotional needs. Some people had lived at the service for a number of years. The manager said the philosophy of the service was a rehabilitation home, not a home for life. People had not been given the support or tools to improve their skills and independence to reach their full potential. People did not have long term plans or goals. For example, some people potentially could move on to live more independently but this had not been planned or encouraged. A relative said, "I would like to see (loved one) home at some point. The manager said they had a 'rehabilitation plan' but I haven't seen it."

Supporting people to develop and maintain relationships to avoid social isolation; support to follow

interests and to take part in activities that are socially and culturally relevant to them
● Activities lacked personal meaning, people had not been assessed as to what they were trying to achieve. One relative said, "I would say there needs to be more activities, I haven't seen activities improve. (Loved one) has everything done for them, they need to improve their self-esteem, they need so much more encouragement."
● One person previously liked to cook, garden, socialise and led a very active lifestyle. The manager said the person had only recently been encouraged to help do cooking as the kitchen had always remained locked. During the inspection we observed the person wandering around the service and was not often engaged in any activity.
● The service was isolated. There was one company car that people could use but this was limited if other people had to attend health appointments or if drivers were unavailable. A staff member said, "I have no clue what everyone is going to do today, they might go out, but the car might not be there as someone has gone to hospital. Not all staff can drive and sometimes there's a problem with drivers."
● Some people could go out independently, others under a DoLS authorisation were unable to go out without staff support. A staff member said, "Some people like to do arts and crafts indoors. We do lots of activities indoors as much as possible."

The provider had failed to involve people in planning their care and people did not receive person-centred care. This was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● The manager was in the process of updating care plan information to be more person specific and in a format that met people's needs.
● Some information was available in an easy to read format for example, the complaints policy. How information is shared with people continues to be an area that requires improvement.

Improving care quality in response to complaints or concerns
● The complaints procedure was in an accessible format and included up to date, relevant information of how people or other individuals could complain.
● Complaints had been documented and investigated and a response to the complainant was sent. There were no open complaints at the time of our visit.

End of life care and support
● There was nobody receiving end of life care at Phoenix House.
● There was a document called 'When I die' which asked people about their wishes at the end of their lives. Question included whether the person preferred to be cremated or buried, what they would like to wear, what music and readings they preferred and what kind of flowers they wanted if any.
● Most staff had received training in end of life care to support people should there be a need in the future.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate.

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

At the last inspection on 05 and 12 September 2018 we found checks and audits had been completed on all aspects of the service including care plans, medicines and recruitment. These audits had identified shortfalls and action had been taken to rectify these. However, the audits and action plans required development to give more detail about the action taken. Although an outside consultant and the provider completed audits of the service shortfalls had not been fully rectified.

At this inspection improvements had not been made. Significant concerns remained regarding the provider's continued failure to ensure the service was safe and well led.

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

● This is the sixth consecutive inspection where the service has been rated either Requires improvement or Inadequate. There has been no sustained improvement. Ratings in all domains apart from Responsive (which has remained the same) have deteriorated since our last inspection in September 2018. The provider has failed to provide robust oversight of the service.
● The management of the service was not stable. Numerous managers had been employed at the service over the years. This had impacted on the staff team and people as there was no clear leadership or direction. The provider had taken little action to stabilise the service or improve outcomes for people. The registered manager was no longer working at the service. The provider had appointed a new manager and they started working at the service in August 2019.

● There was poor accountability. Staff, including the management team were not clear about their roles or responsibilities. For example, although the body maps of unexplained bruising had been recorded, none of the staff team, including management had taken responsibility for using this information to understand how this had happened. The provider had not taken additional steps to ensure safeguarding concerns were quickly dealt with although there had been a significant safeguarding incident in February 2019. The providers audits did not identify the risks we found around people's health needs or the inappropriate use of medicines.
● The provider had not ensured people were kept safe and did not demonstrate a proactive approach to improving standards at the service. The provider had failed to mitigate risks, there was a lack of robust

auditing and review of the service being provided to people. The provider had not made or sustained improvements at the service which had impacted on the quality of life people had. This will be the sixth inspection since 2015 and the provider had not made significant improvement at the service, leaving people with poor care and support. The provider has not taken its responsibility seriously which has meant the people living at the service had a poor quality of life with limited opportunities.

The provider had failed to assess, monitor and mitigate risks. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had not ensured the required notifications had been sent to CQC as required. One safeguarding incident had not been notified to CQC regarding an incident where a person had physically assaulted another person. The incident had been reported to the local authority.

The provider failed to notify CQC of reportable events. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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

● The culture at the service had not been inclusive or empowering for people. The service felt institutionalised and had a closed culture with limited links to the community. People lived with restrictive practices in place which went unchallenged by the provider and staff. People did not thrive at this service or have opportunities to engage with wider society in a meaningful way. The manager had begun to develop people's day to day skills and independence although the provider had not acted to change the culture prior to this. We had reported at previous inspections how staff did things for people rather than with them, and this continued.

● There was a lack of oversight, scrutiny and governance. Staff said before the manager had taken up post in August 2019 they did not feel consulted or involved in making decisions at the service. One staff member said, "(Manager) is the fourth manager since I've been here. Since (manager) has been here things have changed more in one month then they did in a year. (Manager) has made the records much easier so we can spend more time with the residents. The residents are more independent. (Person) used to have a set amount of money each day, now they get money each week which they can choose how to spend."

● The service's vision and values to offer rehabilitation to people had not happened. People were offered limited opportunities to learn new skills or maintain previously developed skills.

Continuous learning and improving care; 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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● The provider had visited the service on the 12 September 2019. They checked areas such as the environment, safety, and medicine. They had failed to identify the concerns we found in relation to safeguarding, medicines, or health management. This did not demonstrate robust monitoring to inform improvement or learn from mistakes.

● The provider had failed to demonstrate how they have learned from previous inspections so the people receiving services were provided with safe care and support. The provider demonstrated a lack of responsibility or desire to improve the service people received.

● People had not been fully involved or informed about the service. For example, at the residents meeting in August 2019 the manager had introduced themselves to some of the people living at Phoenix House. Two people asked the manager what had happened to the previous manager. The provider had not engaged

with people about changes in the service.

The provider had failed to identify the shortfalls at the service through regular effective auditing. The service had not improved or developed. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The new manager had put an action plan in place shortly after they had taken up the post and had started to make some improvement. For example, they had improved some practice around medicines such as updating the policy and arranging further training where this had expired. They had given staff specific health and safety tasks to improve accountability and had made improvements to parts of the environment.

● The provider employed a business manager who conducted four monthly audits. Some improvement had been made following the business manager audit in June 2019. For example, analysing any falls that had occurred, obtaining outstanding safety certificates and updating environmental risk assessments.
● In May 2019 people and other individuals were asked for feedback about the service. Some positive changes had been made in response to the feedback received. For example, decoration had started to be updated and people had been involved in choosing paint colours. One person had requested fish and chips be added to the menu which it was. Another person wanted takeaways for some of their meals which had happened. One person said they did not like being pressured to do things which was followed up with staff in the staff meeting.