Phoenix Care Homes Limited

Phoenix House

Inspection report

The Drove
Northbourne
Deal
Kent
CT14 0LN

Tel: 01304379917

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

Summary of findings

Overall summary

This inspection took place on 6 March 2018 and was unannounced

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.

Phoenix House provides accommodation and personal care for up to 24 people who need support with their mental health needs. There were 14 people living at the service at the time of the inspection. The service is situated in its own extensive grounds and gardens in the rural village of Northbourne, which is close to the seafront towns of Deal and Sandwich.

The care and support needs of the people varied greatly. There was a wide age range of people living at the service with diverse needs and abilities. The youngest person was in their 40s and the oldest was in their 70s.

As well as needing support with their mental health conditions, some people required more care and support related to their physical conditions. Some people were able to make their own decisions about how they lived their lives. They were able to let staff know what they wanted and were able to go out on their own.

The service had a registered manager. They started work at the service in July 2017 and registered with the Care Quality Commission (CQC) in December 2017. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The registered manager had not been working at the service full time for some months and was on a phased return working three days a week.

The last inspection was carried out on 7 July 2017. Concerns had been raised by whistle blowers and staff in the local safeguarding team. We found continued breaches of the regulations from our inspection on 13 December 2016. We also found new breaches of the regulations at the July 2017 inspection. The service was rated Inadequate in all domains and was placed in special measures. We took enforcement action and placed a restriction on the provider's registration so that they could not admit any people to the service without prior written consent from the CQC.

The provider sent us regular action plans and updates with timescales stating when they would be compliant with the regulations. We undertook this inspection to check that they had followed their plan and to confirm that they now met legal requirements. Some improvements had been made, however we found some continued and a new breach of the regulations. This is therefore the fourth consecutive time the service has been rated Requires Improvement or Inadequate showing un sustained improvement.

At this inspection the provider had failed to comply with their action plan with persistent shortfalls including the way risk was managed, people's involvement and engagement, governance, environmental risks, recruitment checks, training and induction of staff.

The registered persons continued not to have oversight and scrutiny to monitor and support the service. There was a lack of continuity in the leadership and management of the service, which had impacted on people, staff and the quality of the care provided. There were quality assurance systems in place, which included reviewing and updating care plans, audits, health and safety checks, but these had not identified the shortfalls found at this inspection. Some records could not be located, were not suitably detailed or accurately maintained. Previous breaches of regulations had not been addressed and the breaches continued. Poor record keeping was identified as a breach of the regulations at the last inspection and continued.

Risks relating to people's care and support had not always been assessed and mitigated. Improvements had been made in reducing the risks when people exhibited behaviours that could be challenging but these needed further information to make sure people were consistently supported and safe. Not all environmental risks had been identified. There was a towel rail in shower room that was very hot and posed a risk of scalding. A fire door was propped open by a chair preventing it from closing automatically in a fire. Ineffective risk management was an issue at the last inspection and the breach of regulation continued.

Some care plans had improved but not all care plans contained the information needed to make sure people received the care and support that they needed. Goals and aspirations had not been identified and people were not fully involved in deciding what care and support they wanted. This was identified as breach of the regulations at the last inspection and continued to be a breach at this inspection.

There had been no new people admitted to the service since the last inspection. However, one person had returned to the service from hospital. The staff could not find any information to show that they had re-assessed the person's needs to make sure staff were able to meet their needs. The assessment for another person lacked detail and did not show how potential risks would be managed.

Staff were not recruited as safely as they should be. Staff had not received the training, support and supervision necessary to complete their roles effectively. There were sufficient numbers of staff. The provider had recently employed new staff and when there were shortfalls agency staff were used.

People's physical and mental health was monitored. Staff supported people to make and attend medical appointments. However, supporting people to live a healthy life style was not promoted for all people. There was a lack of support for people who smoked to give up smoking and people were not encouraged to exercise and improve their health. People's end of life wishes had not been considered or discussed with them.

People were not always empowered to have as much control and independence as possible with aspects of their lives. Staff continued to do some activities for people rather than with them. Activities were ad hoc and up to the staff on duty to arrange rather than planned for everyone individually. This was identified as breach of the regulations at the last inspection and continued at this inspection. People's privacy and dignity was now respected. Staff were caring and good relationships had developed between staff and people.

People were protected from harm and abuse. When incidents had occurred the staff followed safeguarding protocols and incidences were now reported to appropriate agencies. Referrals had been made to the local

safeguarding authority when safeguarding incidents had happened. The staff had informed CQC of important events that occurred at the service, in line with current legislation. Accidents and incidents had been recorded but not all had been fully investigated and analysed to ensure action was being taken and to reduce the risks of further events.

People received their medicines safely and when they needed them. Further guidance was needed for when people needed medicines now and again like pain relief to make sure they received their medicines consistently. Medicines were stored safely although each person previously had their own medicine cupboard in their rooms. This had been changed and medicines were now stored centrally in a trolley removing some control from people. People were offered and received a balanced and healthy diet. When people were at risk of losing weight this was monitored and they received a high calorie diet.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. There was now more understanding about staff responsibilities under the Mental Capacity Act 2005 and DoLS. Mental capacity assessments had been completed by the staff to decide whether or not people were able to make decisions themselves. DoLS had been applied for people who needed them.

People told us they knew how to complain and were confident that their complaints would be taken seriously and the necessary action taken to address their concerns. The registered manager had followed policies and procedures to deal with complaints effectively. People and staff had the opportunity to attend regular meetings to give their views and suggest improvements.

The service was clean and there were procedures in place to protect people from infection. Some parts of the service had been decorated and there were plans for further improvements.

There had been improvements with developing relationships with other agencies like social services and the community mental health team. The staff were working more closely with them.

We found new and continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is Requires Improvement but remains 'Inadequate' in Well led and the service therefore remains in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not

enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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?

Requires Improvement

The service was not consistently safe.

Staff were not always recruited safely and the provider's recruitment policy was not fully adhered to.

Risks to people were assessed but there was a lack of guidance to make sure all staff knew what action to take to keep people as safe as possible. Environmental risks were not always identified and mitigated.

People were protected from harm and abuse. Incidents of abuse had been reported to out-side agencies.

Accidents and incidents had not all been recorded and investigated. They were not analysed to ensure action was being taken and to reduce the risks of further events.

People's medicines were managed safely. Guidance for medicines people needed when they were restless or agitated needed further information.

There were enough staff on duty to make sure people received the care and support they needed. The service was clean and measures were in place to prevent the spread of any infection.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People had not been assessed or assessments were not detailed enough when there were plans in place for people to return to the service.

Staff had not received all the training they needed to meet people's needs.

People were supported with their health care needs.

The provider had applied for Deprivation of Liberty Safeguard authorisations when people who lacked capacity to consent, had their liberty restricted, as required by law.

People were provided with a suitable range of nutritious food and drink.

Some areas of the building required repairs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People and their representatives were not fully involved in making decisions about their care and support. People's independence and autonomy was not fully promoted.

People were treated with dignity and respect. People's privacy was respected.

Staff communicated with people in a caring and compassionate way. Some staff knew people well and knew how they preferred to be supported.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive the care and support they needed to meet their individual needs. Care plans did not give enough personal detail on how people preferred to be supported in a way that suited them best.

Some people were able to undertake daily activities but activities for people were limited. Some people had opportunities to be part of the local community.

There was a complaints procedure in place that had been adhered to.

The service was not currently supporting anyone at the end of their life, but there had been no discussion with people and their relatives about how they wanted to be supported at the end of their lives.

Is the service well-led?

Inadequate

The service was not well led.

The provider had not taken appropriate steps to ensure they had oversight and scrutiny to monitor and support the service.

There was a lack of continuity in the management of the service

due to the registered manager's absence, which had impacted on people, staff and the service provided.

Care staff were aware of their role and responsibilities but the management and governance could be more.

Systems for monitoring the quality of care provided were not effective. Records were not suitably detailed or accurately maintained.

Accidents and incidents had not been analysed to look for trends or themes.

Phoenix House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 6 March 2017 and was unannounced. The inspection was carried out by one inspector and an inspection manager.

Before the inspection, we did not ask the provider to complete a Provider Information Return (PIR). 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. This was because we inspected six months ago and had received a PIR in the last 12 months. Before the inspection we looked at previous inspection reports and notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law, like a death or a serious injury.

We met most of the people living at the service and had conversations with five of them. The provider and registered manager were not available. We spoke with the registered manager on the phone after the inspection and gave feed-back about our findings. We spoke with three members of staff, the deputy manager, general manager and the registered manager from the provider's other service. We also spoke with one visiting professional at the inspection. Before and after the inspection we spoke with two professionals who had contact with the service.

We observed how the staff spoke with and engaged with people. We looked at how people were supported throughout the day with their daily routines and activities. We reviewed five care plans, and looked at a range of other records, including safety checks, records kept for people's medicines, staff files and records about how the quality of the service was managed.

We last inspected this service on 7 July 2017 when breaches in the regulations were found. The service was placed into special measures and we took enforcement action by placing a restriction on admissions to the

service.

Requires Improvement

Is the service safe?

Our findings

People told us that they liked the staff who worked with them and that they got on well with the majority of them. One person said, 'Sometimes we have agency staff but I have got to know the new staff now and they are O.K".

Staff had not always been recruited safely. We checked the recruitment process for new members of staff. One reference from a previous employer indicated that there had been some issues and the staff member's employment had been discontinued. The staff member's information on their application gave a different account of events. Neither the registered manager nor the provider had followed this up. Another staff member had a previous job in social care and had given their previous employer as a reference. No reference had been received from the previous employer and this had not been followed up. Staff were, at times, working alone with people so it was important the provider checked staff's suitability, background and integrity before employing them.

A staff member had declared a health issue. This had not been risk assessed by the provider to ensure the staff member had the support they needed and to mitigate any risks.

The provider had failed to ensure that staff were safe to work with people. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection, the risks relating to behaviours that could be challenging had not been adequately assessed and mitigated. Many of the people who were more vulnerable and at higher risk had moved from the service since then to receive more appropriate care and support from other services.

Some improvements had been made regarding assessing risk but there was scope for further development in managing behavioural risks. The risk assessments varied from person to person. For example, one person's risk assessment stated 'give ample time and space to prevent the situation from escalating, and use de-escalation techniques should the situation need it'. The assessment did explain how staff would give the 'time and space' and what the de - escalating techniques were that would best suit the person. There was a risk that staff would use inconsistent approaches when dealing with a risky situation. Some staff were able to say how they would support people in these situations however, there were some new staff and agency staff so clear guidance was needed to ensure people received consistent support.

Other risk assessments gave details on how risks were identified and how to manage them. For example when people were at risk of not taking their medicines as prescribed there was step by step guidance on what staff needed to do to support the person to take their medicines safely and on time. When new risks had been identified risk assessments had been updated.

Accidents and incidents had been recorded. The registered manager kept a log of the accidents and incidents. There was no analysis or oversight of some of the accidents and incidents so triggers, patterns and interventions had not been identified to try and reduce the risk of re-occurrence.

At the last inspection there was a risk that people may not be as safe in the event of a fire. At this inspection improvements had been made. Each person now had a personal emergency evacuation plan. All but 2 staff had attended fire awareness training and regular checks were carried out on the fire prevention and detection system. Previously, there had been incidents of fires involving matches and cigarettes. At this inspection, when people smoked action had been taken to reduce the risk of fire from cigarettes and matches and there had been no further incidences.

However, other environmental risks had not been identified and mitigated. An uncovered metal towel rail in the ground floor shower room was very hot, too hot to touch. This shower room was used during the inspection, staff told us that 'nearly everyone' used the shower room on a regular basis. The hot towel rail posed a risk of burns; the provider had not identified or mitigated this risk. The general manager took immediate action and turned the thermostat down to reduce the temperature. However there was no way of locking the thermostat so it could easily be turned up again. A fire door leading to the small kitchen was propped open with a chair, so if a fire had occurred this door would not have closed leaving people at risk. Staff told us the door was propped open to remind people to go into the kitchen to help themselves to drinks. They had not considered other, safer ways of keeping the door open.

An inspection of the windows had been carried out in December 2017 and noted that some windows did not open and one was in a 'bad condition.' There was no plan to address these issues.

Risks to people had not been identified, assessed and mitigated. The provider had failed to ensure that care was provided in a safe way to people. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

People told us that they thought the service had improved since the last inspection. They said they felt safe and thought the service was calmer since some people had moved. People felt that the staff would listen to them and take action if they had any concerns. Staff reminded people about personal safety when they went out for example, asking what time they expected to be back.

Visiting professionals said that the staff were now informing out-side agencies when there were incidences that affected people's safety and they felt that the registered manager took the appropriate action.

At the last inspection people were not fully protected from harm and abuse. At this inspection improvements had been made. When incidents of suspected abuse had occurred the staff had followed safeguarding protocols and procedures. Referrals had been made to the local safeguarding authority when safeguarding incidents had happened so they were aware of them and could take the necessary action to investigate. The staff had recorded that the incidents or accidents had happened but there was no information about what the trigger may have been and what action they had taken to make sure people were protected. Incidents had reduced at the service and there was a more consistent approach from staff so people received the support that they needed. Staff were trying to manage each incident but inconsistent support from staff and that lack of oversight of the incidents collectively meant that incidents continued with no lessons learned and people continued to be at risk of harm and improper treatment.

Most staff had attended training about how to safeguard people from harm. Staff we spoke with could tell us about different types of abuse and who they would report to. People were protected from financial abuse. Some people took control of their own money. For others their money was kept securely on their behalf and managed by the staff. Staff kept receipts and checked balances each day. The records we saw were clear and up to date.

There was no tool to establish how many staff were needed to meet people's needs. The registered manager therefore had to judge how many staff were needed. The rota showed that there was usually five staff on duty and the business manager confirmed this. People told us there was enough staff on duty to meet their needs. They said staff were around when they needed them. Staff said they could do with more staff to enable them to take people out more. Staff said they had to carry out the cleaning each day as there was no cleaner and this impacted on the time they had to spend with people. On the day of the inspection one staff was doing the cleaning and another one was doing laundry, these staff were part of the support staff compliment and not in addition to it.

We observed that staff were around the service and no one was rushed, nobody had to wait to go out for a cigarette or for a bath, staff responded promptly to people's requests for support. The rota showed staffing levels were consistent with agency staff used to cover shortfalls on day time shifts but mostly to cover waking night shifts. The business manager said they were trying to recruit to vacancies so they had permanent members of staff rather than using temporary agency staff.

The parts of the service we saw were clean and smelled fresh. A member of staff was allocated to cleaning duties during the morning as no cleaner was employed. A second member of staff was allocated to laundry duty; this took two staff away from directly supporting people. We observed that no person was supported to help with the cleaning or laundry although staff said one or two people did do their own laundry. Staff said people were not interested in cleaning; this had been accepted rather than trying to get people more involved to develop their skills, confidence and self-esteem.

The provider had a policy about infection control that staff could refer to if and when needed. The service had failed a recent infection control audit as some staff had not completed the required food hygiene safety training. The registered manager asked a staff member in December 2017 to complete the training as it was overdue but they had still not completed it.

People had received their medicines safely and when they needed them. They said that they received their medicines on time. One person said, "They (the staff) always make sure I have my tablets. It's important that I take them".

The registered manager had changed the way people received their medicines. Previously people received their medicines in a more personalised way as they each had individual cabinets in their room where their medicines were stored. This had been changed on the advice of the pharmacist as the temperatures in bedrooms on occasions succeeded the recommended limit. Rather than think about how the temperature of each medicine cabinet could be lowered medicines were removed from people's rooms and placed in a communal trolley taking away people's control of their medicines.

There were policies and procedures in place for staff to refer to about medicines. People's medicines were managed by staff. Medicines were stored in a locked room and were administered from a medicines trolley. Some people needed to have their bloods checked regularly when receiving some medicines and some people went to specialist clinics for injections. Staff made sure that people attended appointments to make sure they received their medicines safely and when they needed them so that their mental health remained stable and was regularly monitored by specialist's services.

There was evidence of stock rotation to ensure that medicines did not go out of date. Bottles of medicines were dated when they were opened so staff were aware that these items had a shorter shelf life than other medicines, and this enabled them to check when they were going out of date. When staff gave people their medicines they signed the medicines administration records (MAR). The medicines given to people were

accurately recorded. The room and fridge temperature were checked daily to ensure medicines were stored at the correct temperatures.

Some people were given medicines on a 'when required basis', these were medicines for pain like paracetamol or medicines to help people remain calm. People were asked by staff if they were in pain and if they needed any 'pain relief'. There was guidance for each person who needed 'when required medicines' for pain and staff checked that the pain relief medicines were working effectively. For other 'when required' medicines including medicine to reduce anxiety, the guidance explained when and why the person should receive the medicine. This could contain more detail to make sure people were given this type of medicine consistently including when it should be given, why, maximum doses and how long is needed between doses. People's medicines were reviewed regularly by their doctor to make sure they were still suitable.

When people had skin conditions and needed support in applying creams to their body there were body maps in place to inform staff where the creams needed applying. Creams were dated when opened to make sure they remained effective.

Requires Improvement

Is the service effective?

Our findings

People told us that they thought the staff were good at what they did. A visiting professional told us that the staff they had spoken to had good knowledge of people and their needs. Staff told us they thought they received all the training they needed but sometimes struggled to find the time to complete all the courses. Our inspection found that further improvements were needed.

At the last inspection there were breaches of the regulations with regard to staff training, mentoring and supervision. At this inspection although some improvements had been made there continued to be shortfalls in staff training and competency. Most of the training was on line training via computer. Staff said they did not always have time to complete the courses during their shifts. Consequently, some staff had not completed the provider's mandatory training including food safety, safeguarding people from abuse and health and safety.

Training related to people's needs and current best practice was very limited. This included mental health awareness, learning disabilities and person centred support. There continued to be a lack of person centred support for people. People were still not fully supported to be involved in all aspects of day to day life at the service and not everyone was supported to be part of their local community and be engaged in meaningful activities and to make real choices. The provider had not invested in staff's training and development to give them the skills to give people real person centred support.

New staff completed a basic induction that was not in line with the Care Certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected in health and social care workers. Staff competency was not assessed in any way, so there was no way of ensuring that staff had met these fundamental standards. The induction consisted of 3 pages listing policies and procedures with initials added. New staff had completed some on line training but nothing related to people's needs and conditions.

Staff were trying to engage people with games and puzzles and during the afternoon and some people helped to bake some cakes. This was not planned; activities were ad hoc and depended on what staff were on duty and what skills they had to get people involved. Some people had complex needs so staff needed training and skills to get people involved and to have a voice about their lives.

Most of the staff had met with the registered manager for a supervision meeting at least once since the last inspection but not all. Staff had not had a yearly appraisal to reflect on the year's performance and to plan training and development for the year ahead.

The provider failed to ensure that staff were suitably qualified, competent, skilled and experienced. The provider failed to ensure persons employed received such appropriate support, training, professional development, supervision and appraisal as necessary to enable them to carry out the duties they are employed to perform.

This is a continued breach of Regulation 18(1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

No new people had been admitted to the service since the last inspection. However, two people had been in hospital and one had returned to the service. Staff could not show us the re-assessment of the person prior to them returning to Phoenix House. Staff said they had attended a meeting prior to the person returning but there was no information to identify if the person's needs had changed and what care and support they would need on their return. Their care plan and risk assessment had been updated when they were back at the service. We saw another admission assessment. The quality of the assessment was poor and did not identify how the person's behaviour would be managed and how risks would be mitigated. There was no further information on the best way for staff to support the person. The assessment was not based on current best practice.

At the last inspection people did not always receive the support they needed to manage their health care needs. At this inspection improvements had been made and people and staff were working more closely with specialist services. However, there had been an occasion when a person could not undergo a medical investigation as the staff had failed to read and pass on information about omitting a tablet before the investigation. The person's appointment was delayed due to this staff error and had to be re-scheduled. The registered manager took action to prevent this happening in the future.

People's physical and mental health needs were recorded in their individual care plan. A healthy lifestyle was not promoted, most of the people at the service smoked cigarettes. Some people had access to their cigarettes and smoked outside in a smoking shelter when they wanted to; others were allocated one cigarette each hour. Smoking increases risks to people of serious health conditions including cancer. Smoking had become accepted rather than supporting people in different ways to give up smoking. People were not supported to take regular exercise to aid good health and wellbeing. Two people went out during the inspection for a walk and two others went out in the car for a health appointment and had lunch out. Everyone else spent the day at home, some people walked around the hallways; otherwise there was no regular exercise on offer.

People's physical and mental health was monitored and when it was necessary health care professionals were involved to make sure people were supported to remain as healthy as possible. People told us, "I see my doctor when I need to and I have appointments with the psychiatrist" and "Staff make appointments for you and take you to appointments".

People were supported to go to the GP, dentist and optician; appointments had been made for blood tests to monitor people as specified when prescribed specialist drugs. Most people had regular appointments with the local mental health teams.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are 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 were being met. The registered manager had applied for DoLS authorisations for some people and these had been granted. These authorisations were applied for when it was necessary to restrict people for their own safety. The restrictions in place were as least restrictive as possible. Some of the people living at Phoenix House had full capacity to make their own decisions about how they lived their lives and this was respected by the staff.

At the last inspection the staff had not completed Mental Capacity Act and DoLS training and did not have an understanding of when it would be necessary to make a DoLS application or what it involved. At this inspection some improvements had been made and some staff but not all staff had attended training about the MCA. Staff we spoke with had an understanding of MCA. We saw staff supporting to people to make decisions during the inspection.

Improvements had been made in how the staff worked with other organisations like the community mental health team and social services. Staff were contacting other agencies when they needed support and were working in a more collaborative way to make sure people received the care and support that they needed when they needed it. This could be further developed to include other organisations, like Mind and other organisations.

People told us that they enjoyed the meals and there was always a choice. One person said they had been supported to lose weight by healthier eating.

People had a say about what meals were on the menu, this was discussed at 'resident meetings.' There was a four week rotating menu, no alternative meals were shown on the menu but the cook said they would cook other meals if a person did not like what was on offer. The day's menu was written on a board in the dining room so people knew what they were having. Snacks including fruit were available in between meals and there were plenty of supplies of food, fruit, vegetables in the stores. The kitchen was clean and organised but people continued to have little involvement with going out to buy food and to prepare food. The cook ordered the food shopping from a supermarket on line and it was delivered. Fresh meat and vegetables were also delivered from local suppliers so people did not get regular opportunity to go to local shops and larger supermarkets to buy their food. People on occasions went to the local farm shop to buy fresh vegetables but they said this did not always happen.

Opportunities to be involved in preparing meals had improved but continued to be limited with a cook preparing a cooked lunch. If people wanted to they could get their own breakfast and they were supported to make drinks and cook cakes. Staff said some people did not want to be involved so this had been accepted rather than revisited and reviewed so other techniques and ways of getting people more involved could be tried out.

At lunchtime some people sat together and chatted. Other people choose to eat their meals in other areas. There was a relaxed and friendly atmosphere. People were supported and encouraged to eat a healthy and nutritious diet. People were able to have their meals when they wanted them. When people were at risk of losing weight they were given meals fortified with extra calories and encouraged to eat snacks to maintain their weight.

Phoenix House was a large house within its own extensive grounds. Some areas of the service were in need of repair including a small conservatory. There was a sign on the door saying the room was dangerous and it should not be used however the door was open. One staff said it was because the roof leaked and the floor became slippery and another staff said the door should be locked because the roof was in danger of

collapse. One of the managers said the provided intended to repair the conservatory roof.

Requires Improvement

Is the service caring?

Our findings

A lot of the people at the service had lived there for many years. They said they were very happy living at Phoenix House and would not want to live anywhere else.

People said, "The staff are kind and listen," another person said, "It's OK here now. Things have got better" and "My family visit. They can come at any time and I go and see them".

At the last inspection people were not always treated with dignity and respect that promoted their independence and autonomy. At this inspection some improvements had been made but there continued to be shortfalls.

Although feedback from people was positive, people were not always encouraged to be as independent as possible. People living at the service had a wide variety of needs. Some people were extremely able and could come and go as they pleased. As at the last inspection people were not always supported to be as independent as they could be. However, we continued to find that opportunities for people to develop their skills were limited.

People were not fully involved in planning their own care and deciding what they wanted to do. Staff did not include and actively encourage people to take part the day to day running of the service, like doing their laundry, cleaning their rooms. This had been discussed at previous residents meetings but we could not find evidence that action had been taken to support people's independence. Staff did for people rather than with people.

On one occasion a person asked a staff member for a cup of tea, the staff member stood up and said "I will get you one". It was suggested by the inspector that the person be supported to make the tea themselves. The staff member then asked the person did they want to do that, the person said 'Yes' and went off happily to make their own tea. Once again we saw staff doing things for people and not with people.

Staff did people's laundry, they tidied their rooms and they served people drinks without involving people. We did not see staff approach people and asking them if they wanted help. Staff continued to be task orientated and felt they had to get certain things done at certain times. There seemed to be no flexibility about when tasks were done, therefore not giving people the opportunity to decide when they would like to do things. Some people were more independent and were able to do more for themselves like go out and wash the dining room floor after lunch.

We spoke with staff about people's involvement in the running of the service and staff gave us individual examples, including helping prepare sandwiches for tea and one person who did their own laundry. These individual examples showed that some people were able to carry out household tasks, but there was no plan in place to increase people's independence or support those with more complex needs to participate in the running of the service. People had things done for them, and although staff treated them with kindness, opportunities to increase their independence were limited.

People's independence and autonomy was not fully promoted. This was a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was caring interactions between staff and people and a relaxed and calm atmosphere. People were comfortable with the staff that supported them. People chatted and socialised with each other and with staff and looked at ease. People helped each other. Throughout the inspection exchanges between people and staff were caring and respectful. People were included in conversations and staff explained things to them and took time to answer their questions.

People's rooms were personalised with their own possessions, they had their own things around them which were important to them. If people wanted they had a key to their bedroom door and were able to go to their bedrooms whenever they wanted.

There was personalised information about people's background and life events. Staff had knowledge about people's life history so they could talk to them about it and were aware of any significant events. People who were important to people like members of their family and friends were named in their care plan. This included their contact details and people were supported to keep in touch. People went to visit their families and spend time with them and relatives and friends could visit people at the service at any time. One member of staff told us, "Staff and clients get on well; we like each other".

People's privacy and private space was respected. Staff knew when people wanted some privacy or space and made this happen. People were addressed by their chosen name and told us they got up and went to bed at the times they wished. Staff knocked on people's doors and waited to be invited in. When staff wished to discuss a confidential matter with a person they did so in private.

When people needed additional support to make decisions about their care and support an advocate was available. An advocate is an independent person who can help people express their needs and wishes, weigh up and make decisions about options available to the person. They represent people's interests either by supporting people or by speaking on their behalf.

From April 2016 all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand so that they can communicate effectively. Some people were living with a mental health condition or a learning disability. Information was not always provided in a larger font or easy read format. This was an area for improvement.

Requires Improvement

Is the service responsive?

Our findings

People said, "It's alright here. I like my key worker. I have lots of friends" and "I have a key-worker now. They are brilliant. I can go and talk to them whenever I want. Everything is better, it's all been sorted". Visiting professionals told us that plans for people's care were improving but there was still work to do.

Staff said they thought that people were getting the care and support that they needed. They said "We always ask people if they are happy with the support they are receiving and we change things to suit the clients". The registered manager stated that they knew that people needed to be more involved and was looking at ways to make sure this happened consistently.

Since the last inspection everyone living at Phoenix House had been reviewed by social workers and care managers to make sure they were safe and receiving the care and support that they needed. Some people had moved to other more appropriate services.

No new people had moved into the service since our last inspection. People's care plans were in the process of being reviewed and updated but people were still not fully involved with this. The guidance and information in people's care plans varied. Some care plans contained detailed information about how to care and support people and others were lacking in detail. The registered manager was introducing a new care planning format which would involve people in planning their care but this had not yet been implemented. People did not have formal goals in place so were not working towards becoming more independent and people with more complex needs, needed additional support to make their aspirations and goals known.

On the day of the inspection there were no planned activities taking place. People continued to have no individual activity plan. People who were able went out on their own. Two other people went out with staff attending medical appointments. Staff did organise some table games but this was done spontaneously and was not organised and structured so people were not very enthused and got bored easily. People told us that they would like more to do.

People told us that there were more activities out-side the service but there were times when transport was a problem and they could not do what they wanted because the company vehicle was being used to take people to appointments.

The service was not currently supporting anyone at the end of their life. People had not been asked what their wishes were and what support they would like when they reached this stage of their lives.

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

There was more information about when people displayed behaviour that could be challenging and

incidents were documented. There were some details about what triggers might lead to a person becoming distressed. There was information about the early signs to look for or what action the staff needed to take to support the person in a way that suited them best.

Some people learning disability needs. There was now information in their care plan about their learning disability needs and how best to support people with certain learning disability conditions.

There were regular 'service users meetings. At the meeting in October 2017 people had suggested, they would like to go bowling, do more baking, go swimming and they would like have tea and biscuits during the meeting, at the January 2018 meeting these suggestions had been acted on. People did go out regularly to a local disco which they enjoyed.

People were keen to tell us about the introduction of French lessons which now happened every week. People were enthusiastic about this and felt they were learning something new. There was also a book club when a range of different books were brought to service for people to borrow and enjoy.

People we spoke with did not have any complaints about the service. People and staff told us that when they had complained the registered manager had responded and tried to put things right. One person said, "I have no complaints. Everything is fine by me" and "I go to the staff if I am worried. They sort things out."

The provider had a complaints procedure that was displayed at the service. There was also information displayed about advocacy services with contact details if people needed support to share their views. Both were written in text and not provided in any other format that may be more meaningful to people living with mental health conditions, dementia and/or learning disabilities. There was also a suggestion box available were people could write any concerns and suggestions anonymously. One person told us, "We don't really use the box, we just go to staff".

There had been two complaints since the last inspection. The registered manager had recorded, investigated and responded to both complaints.

Inadequate

Is the service well-led?

Our findings

People said, "Everything is so much better since you were last here. The new manager has made changes". Staff told us, "It's a 100% better since the new manager came. There is a better atmosphere. We are all more positive about the future".

Visiting professionals told us that the service had improved within the last six months but also said there was more work to be done to make sure improvements continued and were sustained.

The last inspection took place in July 2017. The service was rated Inadequate in all five domains and placed in special measures. We took enforcement action against the provider who sent us action plans regularly telling us about the improvements they had made and what further improvements were planned. At this inspection the provider had failed to comply with their action plan and there were continued breaches of the regulations relating to safe care and treatment, promoting people's independence and autonomy, person centred care, staff training and support and good governance. There were also a new breach identified relating to the recruitment of staff.

Since the last inspection a new manager had been appointed and had registered with the Care Quality Commission. Improvements and changes were being implemented but due to unforeseen circumstances since Christmas the registered manager had not been at the service for some time and was now on a phased return working three days a week .The service seemed to have stopped developing further and was 'ticking over' and not moving forward.

Neither the registered manager nor the provider was available for the inspection. The deputy manager and the business manager supported the inspection, telling us the provider was 'away.' The registered manager was experienced in managing care homes. We contacted the registered manger by phone after the inspection and gave feed-back of our findings. They told us that they realised that more improvements were needed.

At the last inspection there was a lack of leadership and direction and there was a lack of oversight, scrutiny and governance this continued to be the case due to the registered manager's absence. The improvements that started had not been taken forward in the registered manager's absence.

Some records we asked for could not be found, we were told that some records were with the registered manager, or on their password protected computer and could not be accessed. One of these records was an assessment for a person who had recently moved back to the service. This information should have been shared with staff to give them some knowledge and understanding of the person's needs but it could not be accessed in the registered manager's absence.

The registered manager had started to update records and subsequently for some topics there were two files, including staff supervision and quality assurance. Outdated information had not been archived so there were lots of files in the registered manager's office on a table and on shelving making it difficult for

staff to find the most up to date information.

People were asked for their views during regular meetings which most people attended. The focus of the meetings was mainly the menu and activities. People said they wanted to do more activities and had made suggestions including gardening. Some of the activities had taken place for some people although people continued to have no structured programme of activities and opportunities to develop and learn. One person said they would like more pets so staff purchased a goldfish and fish tank and said they 'would see how people got on with looking after the goldfish' and may consider getting a rabbit in the future.

Staff were invited to attend staff meetings to share their views and opinions about the service. Staff had raised the issue of activities and said they would like to get people out more. Staff raised an issue of a car attached to the service saying it was too small so outings were restricted to small groups of about four. Increasing opportunities for activities, rehabilitation, well-being and lifelong learning and the car issue was not part of the providers' development plan.

Surveys had been sent to people, their relatives and other stakeholders including care managers, the returned surveys in a file we found were all dated 2016. The business manager said they thought the registered manager had sent out surveys last year but could not find the competed returned surveys. After the inspection we spoke with the registered manager who told us they had received completed surveys. However, the surveys had not been analysed and feedback had not been given to the groups of people who had completed them to show how the service was going to improve. We will check this at the next inspection.

Some audits and checks had been carried out but there was not always an action plan to follow up the issues picked up by the audits. For example, an audit of windows had been carried out in December 2017 and found some windows did not open, some did not close and one was in a 'bad condition.' There was no plan to repair the windows. Accidents and incidents had not analysed to identify trends and patterns to reduce the risk of them happening again.

Some environmental risks had not been picked up. An unguarded metal towel rail in the ground floor shower room was very hot, too hot to touch. This shower room was used during the inspection, staff told us that 'nearly everyone' used the shower room. The hot towel rail posed a risk of burns; the provider had not identified or mitigated this risk placing people at risk of harm.

The service had not sufficiently improved or developed. The provider had failed to maintain accurate and complete records. The provider had failed to establish and operate systems to assess, monitor and improve the quality of the services provided and reduce risks to people. This was a continuous breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Previously there was a lack of transparency and openness. Improvements had been made. The registered manager now raised concerns with the relevant agencies when it was necessary to make sure people were safe and protected. When staff had raised concerns with the management the appropriate action had been taken. The registered manager contacted support organisations and the CQC when they were unsure or needed support and advice. Staff were aware of their roles and responsibilities.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service this was so the CQC check that appropriate action had been taken. At the last inspection the registered person had failed to do this. At this inspection improvements had been made and notifications had been submitted in line with guidance.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service and on their web-site if they have one. This is so people, visitors and those seeking information about a service can be informed of our judgements. The provider had displayed the rating conspicuously in the service and on their website.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to consistently involve people and their relatives in planning their care and people did not always receive person-centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's independence and autonomy was not fully promoted.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people had not been identified, assessed and mitigated. The provider had failed to ensure that care was provided in a safe way to people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service had not sufficiently improved or developed. The provider had failed to maintain accurate and complete records. The provider had failed to establish and operate systems to assess, monitor and improve the quality of the services provided and reduce risks to people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure that staff were safe to work with people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure that staff were suitably qualified, competent, skilled and experienced. The provider failed to ensure persons employed received such appropriate support, training, professional development, supervision and appraisal as necessary to enable them to carry out the duties they are employed to perform.