Phoenix Residential Care Homes Limited

Phoenix Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 10 October 2017. The inspection was unannounced.

Phoenix Residential Care Home is registered to provide accommodation and personal care without nursing for up to 18 people. There were 18 people living at the service at the time of our inspection.

People living in the service required care and support and had varying needs. Some people were living with dementia and some people had medical conditions such as diabetes or respiratory conditions and some people were recovering from suffering a stroke. Most people living in the service were mobile, some independently mobile and others needed the support of one or two staff. No people were unwell enough to be cared for in bed.

The service was set out over two floors in an old building on a busy main road into the town of Chatham. Bedrooms were available on the ground floor and the first floor. Most bedrooms, all except two, had an en-suite toilet. A passenger lift was available to take people between floors.

A registered manager was employed at the service. The registered manager was also one of the providers of the service. A registered manager is a person who has registered with the Care Quality Commission 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 2008 and associated Regulations about how the service is run.

Phoenix Residential Care Home was last inspected on 30 August 2016. Two continuous breaches of legal requirements were found in relation to Regulations 11 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one other breach was found in relation to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection the provider sent us an action plan which detailed how they planned to address the breaches of Regulations. The action plan did not specify a date when they intended to be compliant by.

At this inspection we found that improvements had been made in all the areas of concern found at the last inspection. However, we found new concerns and improvements that were required in each of the five domains.

Some elements of how medicines administration was managed needed improvement. Prescribed thickeners to add to people's drinks to prevent choking were not stored or administered safely. Medicines audits did not highlight concerns found. Guidance for staff when administering 'as and when necessary' medicines were not in place.

Staff did not keep consistent records of people's care. Daily records were not always completed. Documents

did not show if people had been referred to appropriate health care professionals. Care plans were in place but not always up to date or consistently capturing people's care and support needs or preferences.

People's hobbies, interests and life histories were not used to provide person centred care and meaningful activity to maintain well-being.

The registered manager had processes in place to undertake regular audits to check the quality and safety of the care provided. However, these audits were not robust. They did not identify concerns we had found during the inspection and did not always record who had completed the audit or the action required when areas for improvement were found.

People and some staff were not always confident about raising their concerns about the attitude of some members of staff. Staff felt they could talk openly about most areas and felt they were well supported generally.

Risk assessments were in place to protect people from the risks of harm. Accidents and incidents were documented, clearly recording the action taken. The registered manager reviewed all incidents to take action to prevent future occurrence.

The deputy manager had a young pet dog that was in the service each day to support their training in socialising with people. Appropriate specific risk assessments were not in place to ensure their safety with people. Not all people were happy with the dog's presence. We have made a recommendation about this.

Effective recruitment procedures were in place to check that potential staff employed were of good character. Appropriate numbers of staff were on the rota to meet people's needs. However, people told us staff were not deployed suitably throughout the day to ensure staff were available to meet people's needs. We have made a recommendation about this.

Staff had received the basic training required to carry out their role. Some specific training to meet people's specialist needs had not been provided. We have made a recommendation about this.

Staff knew and understood how to protect people from abuse and harm and keep them safe. There was a good understanding within the staff team of people's rights to make their own choices and decisions.

Maintenance of the premises had been routinely undertaken and records had been kept. Fire safety tests had been carried out and fire equipment safety-checked.

People did get choices of food at mealtimes. People were not always happy with the meals provided and said there had been a period of time without a cook which had an impact on quality. We have made a recommendation about this.

Some people felt some staff did not always have a kind and caring approach. The temperature in the service was not constant and people were complaining of feeling cold.

Staff supported people to maintain their independence and some people helped out with small tasks when they wanted to.

Complaints made in writing were recorded and investigated appropriately. Verbal and informal complaints had not been recorded or outcomes documented to learn lessons to make improvements. We have made a

recommendation about this.

During this inspection we found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Some elements of medicines administration were not managed well.

Suitable numbers of staff were not always deployed appropriately throughout the day to respond to people's needs. Safe recruitment procedures were in place.

Risk assessments were completed to identify individual risks and protect people from harm.

Staff knew what they should do to identify and raise safeguarding concerns.

The premises were suitably maintained and equipment was appropriately checked.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had received the basic training required to carry out their roles but had not received specific training to meet people's specialist needs.

People did not feel the quality of food at mealtimes was consistently good.

Health records were not kept up to date and it was not clear if referrals to healthcare professionals had been made when necessary to meet people's needs.

Staff understood how to support people to make choices and decisions.

Is the service caring?

Requires Improvement

The service was not always caring.

People did not feel some of the staff had a kind and caring

approach at times.

The temperature in the service was not constant and people were feeling cold.

People were supported to maintain their independence. Some people liked to help out with small tasks and were encouraged to do so.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not kept in a clear order and did not give consistent information about people's needs.

A person centred approach was not used to ensure people had meaningful activity to maintain their well-being.

Informal and verbal complaints were not logged in order to learn lessons to make improvements.

Is the service well-led?

Requires Improvement

The service was not always well led.

The registered manager had a system of audits in place to check the quality and safety of the service. Where improvements were required these were not always recorded and actioned.

Some people and staff felt they could not discuss their thoughts about some members of the staff team.

Generally, staff felt they could raise ideas and felt they were given good support.

Health and social care professionals felt the service had made improvements.

Phoenix Residential Care Home

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 10 October 2017 and was unannounced. The inspection was carried out by two inspectors and one expert by experience who has experience of family members living in a care home. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at notifications about important events that had taken place in the service which the provider is required to tell us by law. We also looked at the provider's action plans following the last inspection. We used this information to help us plan our inspection.

We spoke with 12 people who lived at the service and four relatives to gain their views and experience of the service provided. We also spoke to the registered manager, the deputy manager and four staff. We received feedback from one health professional, one local authority commissioner and two health and social care professionals.

We made observations of the support provided and the interaction between staff and people. We looked in depth at five people's care documentation and at medicine administration records. We also looked at four staff recruitment records, staff training records, the staff rota and staff team meeting minutes. We spent time looking at the provider's records such as; policies and procedures, auditing and monitoring systems, complaints and incident and accident recording systems. We also looked at 'residents' meeting minutes and

surveys.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 30 August 2016 we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured fire safety checks had been undertaken and actions required following a fire risk assessment had not been followed through. We also made two recommendations to the provider regarding safer recruitment processes and a more targeted system to detect developing trends of incidents and accidents.

At this inspection we found that improvements had been made to fire safety procedures. Safer recruitment practices were followed and accidents and incidents were monitored better. However, we found some concerns around medicines management.

Improvements were required in the management and administration of people's prescribed medicines. Some people had thickeners prescribed to add to their drinks to prevent the risk of choking. Due to the risks associated with thickeners by accidental swallowing or incorrect measurements, thickeners must be stored in a locked cupboard as other medicines are. Thickeners must only be given to those for whom they are prescribed. We asked staff where the thickeners were kept and they told us one tin was kept on the drinks trolley and the rest was kept in the medicines room. We found that two people were prescribed thickeners and the one tin on the drinks trolley was used for both people. Labels on the thickeners stated 'use as directed'. No specific instruction was given as to how many scoops each person was prescribed as requiring. We asked staff how many scoops they used and were told one scoop for each person. Staff did not know if this should be a flat scoop or a heaped scoop or if the amount should be altered dependent on the amount of fluid in the drink. This meant that people were at continued risk of choking without the correct guidance and procedures in place for the use of prescribed thickeners. We spoke to the registered manager about this who said they were unaware of the guidance around thickeners. However, they contacted the pharmacist and the GP straight away and had the prescription and thickener labels changed to ensure the amount prescribed was recorded on the label. The newly labelled thickeners were delivered by the pharmacist later that same day. They also made plans to purchase a cupboard for the purpose of safe storage of the thickener containers. The registered manager also immediately stopped the practice of sharing one tin of thickener between two people when they were prescribed individually.

Records of medicines delivered to the service were not always recorded consistently or as prescribed. One person was prescribed Tramacet 37.5mg/325 Paracetamol. This is a pain relief medicine also known as Tramadol. The label on the medicine box stated one or two tabs were to be taken PRN (as and when necessary). The printed MAR from the pharmacy also stated 'take one or two tablets three times a day when required for pain'. However, staff had handwritten a separate record on the MAR to take one tablet at night. The record showed that staff had routinely administered one tablet at night as per the handwritten addition rather than the printed record completed by the pharmacy as per the prescription. One member of staff told us the GP had changed the dose of Tramacet to one at night and the registered manager told us this had changed again to twice a day. There was no record made of these changes which meant the MAR was confusing and the person was at risk of not receiving the level of pain relief required to help them to keep their pain under control. We did not see evidence that the person was in pain during the inspection.

A monthly audit was undertaken by a team leader or the registered manager to check all areas of the management of medicines administration. Although areas for improvement had been identified and some action plans completed to ensure action was taken, this was not the case for every audit. Some areas had been identified as requiring action but records had not been made of what action was required or if any had been taken. One audit had identified a medicines cupboard was coming loose from the wall, however no action had been recorded as taken and the audit had not been signed. The audits had not identified the areas of concern found on inspection.

The failure to ensure the safe management of medicines administration is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

There were no gaps in the MAR charts where staff signed to say they had administered medicines, indicating that errors were less likely to have occurred. The storage facilities for medicines were suitable. Staff checked and recorded the temperatures of the room where medicines were stored and the fridges used for medicines that required cold storage. This meant medicines were kept at suitable temperatures to ensure their efficacy remained intact.

Although we did not find documented protocols for 'As and when necessary' (PRN) medicines among the records we looked at during the inspection, the provider sent evidence following the inspection to show these were in place. Guidance should be available so staff administering PRN medicines knew what the medicine was used for, why people were prescribed the medicine, the side effects to watch out for and the safe levels to take in a 24 hour period.

People gave us their views on whether they felt safe and generally they did. However, some people were cautious about asking for help at times. Comments from people included; "I am safe here I don't have any worries. I don't worry about money anymore and I know I can always get help if I need it"; "I know the night staff come round checking we are all safe at night but I just don't make a sound so as not to cause any trouble"; "The staff are good but can be snappy so I wouldn't say I feel unsafe just cautious of who I ask for help sometimes". We did not observe any impatience by staff during the inspection.

Each person's care plan contained individual risk assessments identifying risks to their safety such as; requiring assistance when moving around the service, falls, developing pressure areas, choking and nutrition. The severity of the risks to the individual had been identified. Guidance about the action staff needed to take to minimise risks and protect people from harm was well detailed in the risk assessments. One person required assistance to get in and out of the bath. It was recorded they needed the assistance of two staff with the aid of a bath chair. The guidance went on to say the person must not be left alone in the bathroom. Some people required the assistance of one or two staff to help them to walk around. This was identified and recorded in people's risk assessment, including where people required the use of walking aids such as a walking frame or stick. We saw staff walking alongside people, guiding them to keep them safe. No people living in the service at the time of inspection required a hoist to help them to move from their bed or a chair.

The service had been without a domestic housekeeper since 31 July 2017. Although a housekeeper actually started in this role on the day of inspection, staff had been completing the cleaning since that time. The new housekeeper had been employed to work five days a week, Monday to Friday so staff were still expected to carry out cleaning tasks at weekends. This may have an impact on the care people received as staff availability may be compromised if they were undertaking cleaning as well as caring duties.

The staffing structure of the service included team leaders and care staff as well as the registered manager

and a deputy manager. A cook was employed as well as the newly appointed housekeeper. A young apprentice was acting as the activity coordinator. Apprentices are aged 16 or over and combine working with studying to gain skills and knowledge in a specific job.

There were suitable numbers of staff available on the staffing rota to meet the needs of people living in the service. Staff covered absences such as annual leave and sickness by working extra hours where necessary. The staff we spoke with told us they thought there were enough staff and they did not feel under pressure. However, the feedback we received from people living in the service and their loved ones suggested an issue with how staff were deployed around the service at certain times of the day. People told us; "Usually people [staff] come quickly if we need help but at some times of the day they are slow and in the night if they are dealing with someone else it can take quite a while to get help"; "Usually the staff are very good but I might have to wait 10 minutes or so sometimes as it is quite strange at some times of the day the staff seem to all vanish"; "I do feel safe but I do worry sometimes when I am on my own in my room at night or first thing in the morning and I can't get any attention or answer from anybody, but then perhaps I am just a panicker" and "I sometimes notice at lunch time that there aren't so many staff around and we appear to be all alone in the conservatory. I don't mind but [person's name] sometimes gets quite vocal and causes an upset". One person who required full staff assistance to get out of bed was still in bed at 11.30 when their relative arrived to visit. They were found to have been incontinent. The person's loved one helped to get them out of bed and dressed. This meant people did not always get the help they required when they needed it.

We recommend the provider and registered manager find a more suitable system of deploying staff to ensure people are not unable to gain assistance when they need it.

The deputy manager had a young dog who they said was being socialised to be able to integrate into the home with people. The dog was still a puppy but a large breed and excitable. The dog was behind a secure gate in the office area. The deputy manager told us the dog was present in the service every day but they decided to take the dog home on the day of inspection to enable the inspection to carry on without disruption. The deputy manager told us a risk assessment had been completed to enable the safe socialisation with people. However, when they showed this to us, the risk assessment was not relating to this particular dog and the circumstances. The risk assessment identified the risks of visitors bringing pets into the service. The young dog was large and naturally boisterous and the risks of it knocking into people who were frail and not always steady on their feet had not been addressed, or control measures identified to minimise the risk and prevent harm. We found no evidence of consultation with people to make sure they were happy to have a dog in their home. One person told us, "The dog just yaps all day and we can't complain".

We recommend the provider and registered manager ensures a robust risk assessment is developed and people are formally consulted about the decision to have a large dog in their home every day.

People were protected from abuse and mistreatment. Staff had a good understanding of their role in safeguarding people in their care from abuse. They could describe how abuse may occur and how they would recognise concerns. Staff were clear about their responsibilities in reporting any suspicions of abuse and knew who they would report these to. Although staff had confidence that the registered manager would act immediately on concerns raised, they also knew who they would report to outside of the organisation should they need to. Staff told us they would go to their local authority Medway Council, or to CQC.

Accidents and incidents were recorded in full, capturing the details of the incident, the immediate action taken and the follow up action required and taken. One person's record showed they had fallen over on 8 October 2017 and was found in their bedroom on the floor having appeared to have banged their head.

Ambulance crew attended to assess for injuries. As they did not require hospital attendance, staff carried out a post fall assessment and completed a body map of bruising. Twenty four hour observations were put in progress and recorded. A follow up call to the GP was made who agreed to refer for specialist advice regarding the possible reasons for the person's falls. The deputy manager carried out an accident analysis quarterly. Following their analysis, action plans were in place and the action taken recorded. Action taken included; moving one person to a bedroom nearer to where night staff were more available; referrals to the specialist falls team and providing bed sensors to alert staff if people stepped out of bed at night. The registered manager monitored accidents and incidents to offer better outcomes for people.

The premises were tired looking and required updating in areas. However, the provider was decorating and improving some areas with plans to continue this. For example, there was no shower available so people did not have the choice and flexibility of having a shower rather than a bath. The deputy manager told us plans were in place to convert one of the bathrooms to a walk in shower. The registered manager had identified this as a need for some people living in the service. One staff member told us, "Improvements needed in the home would be to the environment, the furniture and the décor". A stale odour was present in the service when we arrived and although this improved, an odour continued through the day in some areas, particularly two bedrooms. The registered manager was aware of this and the stale odour had been identified as a problem when audits were undertaken, however it remained a concern. This is an area we have identified as requiring improvement.

The service had been without a domestic cleaner for some months since the last staff member left. This had an impact on the cleanliness of the premises as staff had been required to undertake cleaning as well as caring duties. However, a new domestic cleaner had commenced employment on the day of our inspection and would be working five days a week. The registered manager was intending to continue to look for another domestic cleaner to accommodate the other two days plus annual leave and absences.

The registered manager had fire safety precautions in place to help to keep people safe. A comprehensive fire risk assessment had been completed by an external specialist organisation. An action plan had been developed by the registered manager to address the areas highlighted for action and improvement. The registered manager had signed and dated the completed actions. All fire equipment, alarms and emergency lighting was checked and serviced regularly at appropriate intervals. A fire evacuation procedure was in place with clear steps to take in the event of a fire to safely evacuate the building. People had a personal emergency evacuation plan (PEEP) located in the fire file and a copy kept within their care plan. A PEEP sets out the specific physical, communication and equipment requirements that each person has to ensure that they could be safely evacuated from the service in the event of a fire. The PEEP's were in a format that was easy to read and for staff to follow, providing the information required to support each person to safely evacuate the premises.

Maintenance records evidenced that repairs and tasks were completed as required. Checks had been completed by qualified professionals in relation to legionella testing, asbestos, moving and handling equipment, electrical supply, gas appliances and the passenger lift to ensure equipment and fittings were working as they should be.

The provider kept robust recruitment records to protect people from the employment of unsuitable staff. Any gaps in employment had been discussed with the staff member at the interview stage if they had not been recorded on their application form. One staff member's employment history had not been fully recorded although the registered manager had discussed this with them at interview. This was rectified during the inspection. Other checks on potential employees included obtaining a person's work and character references, and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safe

recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Requires Improvement

Is the service effective?

Our findings

At our last inspection on 30 August 2016 we identified breaches of Regulations 11 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured that people's capacity to consent and make everyday decisions had been assessed in accordance with the Mental Capacity Act 2005. The provider had not ensured that staff had received sufficient training to carry out their roles.

At this inspection we found that training had improved and staff had now received the basic training they required to carry out their roles, although some specific training was still required. The principles of the Mental Capacity Act 2005 were now followed to provide the support people required to make decisions and choices. However, we found other areas of concern during this inspection. Records did not show that people were always given the support they required to meet their health needs.

People said they received the help they needed to maintain their health. One person said, "If I am not well I just have to mention it and they either call a nurse or a doctor if they can't work out what's up". The local GP practice told us they were happy with the care their patients received at Phoenix Residential Care Home. We did find some areas where improvements could be made to maintaining people's health and well-being.

The registered manager used a nutritional risk assessment scoring tool to determine whether people were at risk of malnutrition. Staff had completed one person's risk score which showed they were not at risk of malnutrition. Their weight had been recorded some months although not every month and their weight chart showed they had lost weight. In March 2017 their weight was recorded as 64.1kg and the latest recording on 1 October 2017 was 58.7kg. This meant the person had lost 5.4kg or 12lbs in weight in this time. No reference was made to the loss of weight and the possible reasons for this. Even though they had lost weight, they had not been weighed regularly or consistently. Records were available for 8 March 2017, 29 March 2017, 10 May 2017 and 1 October 2017. There was no evidence that the weight loss had been reported to a health care professional to ensure the person received the appropriate advice and monitoring. A plan was not in place to support the prevention of further weight loss. Another person had lost weight over a longer period of time. In November 2015 they had been recorded as weighing 75.4kg. On 14 September 2017 their weight was now 51.8kg, a reduction of 23.6 kg or three stone and seven pounds. The registered manager told us they had been referred to the dietician, however, there was no record of the referral or of a visit to the person by the dietician.

Some people required staff to monitor their fluid intake. Fluid recording charts were not completed consistently. No fluid charts were available for some dates and others were not fully completed, although others were recorded well. Daily records were not kept in order to ensure they were easily accessible for recording and monitoring purposes. All daily recording charts to monitor people's health were kept loose in a filing cabinet, not in date order or by type of document. This meant a search through the pile of documents was needed to find the particular record required. The registered manager and staff would not be able to monitor and keep a close track of the state of people's health by checking and comparing each set of records as they were completed, such as food and fluid and positional change charts.

One person was found to have a red pressure area on their body and a body map was in place to show where the area of concern was. Staff had been applying a cream used to prevent pressure sores to the area, however, there was no record of whether advice had been sought from a healthcare professional or who had prescribed the particular cream. Another person's care plan detailed they were sometimes incontinent of urine and found this very embarrassing. This meant they would rather sit in wet clothes than ask for help so staff were to discreetly check they were comfortable and dry. There was no record made that the person had been referred to a specialist health care professional to support and advise them and to check if there was a medical reason for their problem.
Two people had a diagnosis of diabetes. Staff told us both people ate the same food as people who were not diabetic as their diabetes was not severe so they were able to have 'normal' food. We were told the only difference was that the people with diabetes did not have sugar in their tea. One person was taking medicine prescribed by the GP to control their diabetes. The registered manager added that that they had asked one of the people with diabetes not to have a hot chocolate drink more than once a day. There was no evidence of a referral having been made to a health care professional to receive guidance in relation to diet and the safe control of diabetes for the individuals.

The failure to provide care and treatment that meets people's specific needs is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The people we spoke with thought the staff knew how to support them. One person told us, "They are very good here, we are really very well looked after". Another person told us, "I don't need much help but I know it is there if I need it".

Staff had received the basic training they required to carry out the role they had been employed to undertake. The provider's training included, dementia awareness, fire safety, first aid, food hygiene, infection control, medicines management, moving and handling and the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Many staff had either completed, or were in the process of completing, the QCF diploma level three in care. The diploma assesses staff's development, knowledge and skills in relation to health and social care. Most staff had received training to develop their skills when supporting people living with dementia. One person had been identified as occasionally having behaviour that others may find challenging and incidents of this nature had occurred. However, no staff had received training to make sure they had the knowledge, skills and confidence to deal with these situations.

Some people required a regular blood pressure check. Although these were taken and recorded regularly, there was no evidence that staff had been trained to carry out this health related task. The blood pressure machine staff were using in the service had never been checked to make sure it continued to record accurately. The registered manager could not be assured that staff had the knowledge necessary to understand what they were looking for and when to seek the help of a healthcare professional. We spoke to the registered manager and deputy manager about this and they agreed this was an area of concern. They said they were going to review their policy regarding taking blood pressure readings to decide whether it continued to be appropriate for care staff to undertake this responsibility.

Although two people had a diagnosis of type 2 diabetes staff had not received training to aid their understanding of diabetes and how to make sure measures were in place to prevent health concerns arising as a result of this medical condition

We recommend specific training requirements are identified to ensure staff are skilled to provide all the care required to meet people's needs and to have a system in place to monitor the specialist needs of people to keep staff training requirements under review.

A menu was in place with choices available each day. People told us that there had been a lot of changes in the kitchen and there had been no cook for some time. One person said, "Breakfast is usually good and you can have a fry up but a couple of times lately we have only been allowed toast as there is no one to cook". Another person told us, "We make our own minds up about what we want to eat on the day but we haven't had a decent cook for quite a while now". A new cook had now been employed and food was improving. The registered manager told us they or the deputy manager covered in the kitchen when the cook was absent. On the day of inspection the cook was on annual leave and the registered manager spent the morning in the kitchen. Lunch was usually served between 12.30 and 13.00. However, on the day of inspection the deputy manager went to buy chips from a local fish and chip shop and lunch was not served until 13.30. People told us they were hungry as they were sitting waiting. Some people had been served a few thin slices of packaged ham with their chips although one of those people had asked for sausages. Others had scampi with their chips. Although the menu had apple crumble listed, this was changed to bananas and custard. No discussion was held with people to agree the changes to the menu.

We recommend the provider and registered manager considers a more consistent approach to regular kitchen staff requirements to provide a more robust approach to meals and nutrition every day of the week to meet the needs and preferences of people living in the service.

The Mental Capacity Act 2005 (MCA 2005) 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 the mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. One person's needs had increased and it was considered it may be appropriate to transfer them to a more specialist service such as a nursing home. However a best interest meeting was held with healthcare professionals outside of the home and other relevant people, where it was agreed that in the person's best interests, they should remain at Phoenix Residential Care Home. This meant a decision had been made based on the collective knowledge of the person to make sure any decision was in their best interests.

People had been asked to give their consent where appropriate. For example, consent for staff to administer their medicines, to provide care and support and for photographs to be taken. Their loved ones were included where necessary and appropriate. Staff had received training and had a good understanding of their role in supporting people to make their own choices and decisions. One member of staff said, "I believe in patience and understanding and to take your time. I take people away from the noise so I can speak to them on our own if they have trouble understanding".

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 2005. The authorisation 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 2005, and whether any conditions on authorisations to deprive a person of their liberty were being met. DoLS applications had been made to the supervisory authority although no authorisations had yet been granted. The registered manager told us they were waiting for independent assessments to be made. The registered manager understood their responsibilities in making sure people's rights were upheld.

Requires Improvement

Is the service caring?

Our findings

People had mixed views about the caring attitude of some staff. We received many comments from people suggesting not all staff were kind and caring on a consistent basis, although it was clear the concerns were about certain staff, not all. The comments we received included; "I would say nine times out of 10 the staff are kind and caring, at least to me they are"; "I would say most of the girls [staff] are pretty kind but sometimes I have to bite my tongue when I hear them shout or be too heavy handed with other residents"; "Sometimes the girls [staff] can be a bit sharp especially at night but then I just keep quiet to avoid getting shouted at" and "The staff are all very friendly and will always stop for a chat if they have time, with only one exception but I won't tell tales". Although we did not observe staff not being friendly and kind during the inspection, some people did raise this as being an issue at times as described above.

People were feeling the cold and asked for blankets to be wrapped around them while sitting in the lounge area. Three people were heard to say they were cold but were told by staff that the heating could not be put on unless management said so. Two people were eating their breakfast in the conservatory, used as a dining room, when we arrived for the inspection. When we went into the conservatory, the room was noticeably cold. We asked if the heating was on and we were told the heating was on a timer. The deputy manager set the heating to come on but it took some time to heat the room up. By lunchtime the room was warm but we noticed it became cold again later in the day. The conservatory/dining room was next to the lounge with a door in between the two. When the door was open, the cold air fed through into the lounge. One person said to a member of staff. "Oh it's still cold here, it's cold". The member of staff placed a blanket around the person. The deputy manager told us they had plans to move the dining room to another room in the service with better temperature control. This is an area we have identified as requiring improvement.

We did not see any evidence that people and their loved ones were involved in reviewing their care plans. When we asked people about this, none of them were aware of their care plans but felt their needs were being met and that the staff knew them and what their requirements were. People's relatives told us they had not been asked to be involved in their loved ones care plan reviews. This is an area we have identified as requiring improvement.

Staff told us they were happy in their role and thought the service was a good place to work. The comments we received from staff included; "I love it here, I get great job satisfaction"; "Everyone [staff] is very approachable. It's like a nice family, there is always someone to help" and "We are very laid back here, there is a lot of laughter and people are happy". However, this was not the overall impression of some people living in the service.

As with the caring attitude of some staff, people had mixed views about whether their privacy and dignity were respected at all times. People told us; "When I am having a bath or a shower I can do most of it but a carer will stand and talk to me and help with the parts I can't reach which is a great help"; "I wouldn't say the staff always knock on my door before entering and certainly don't wait for an answer"; "There are only female staff and I get a wash all over but that's ok, not ideal but I am fine as I have no other choice" and "They are all female staff here, but I don't mind that". As most people were up and about during the

inspection we did not observe staff going in and out of people's rooms.

Staff described how they respected people's dignity and privacy. One member of staff said, "We must respect people at all times. For example, by making sure people are covered up when providing personal care, keeping the bedroom door shut and speaking to people quietly and privately". Another staff member told us, "If someone has an accident [incontinence] I keep it very quiet and take them quietly to their room or bathroom to help sort them out".

People were supported to maintain their independence. Some people were able to move around independently and some with the assistance of a walking aid. One person told us, "The staff do help just enough so we can do things our self if we prefer". One person enjoyed helping out around the service and was encouraged to do so. They laid the tables for mealtimes and sometimes helped out in the kitchen, tidying up after meals or helping with some of the smaller meal preparation tasks. They told us, "I come and go from my room as I please and I do like to help around the place when I can so I do. Makes it more like home". Staff told us they made sure people maintained their independence by doing as much as possible for themselves. One staff member said, "It is really important for their state of mind to do what they can so we encourage this".

Requires Improvement

Is the service responsive?

Our findings

People did not have many positive comments about the activities on offer to them on a day to day basis. We did not see evidence that activities were planned around people's interests and hobbies. One person was knitting but this was taken off them at one point and placed on a shelf out of their reach and they were not given their knitting back again. People told us; "It does get boring, I do sometimes feel like my life is just ebbing away"; "I don't like joining in with the activities as it gets so loud I have to leave the lounge"; "I can't say we ever get taken out anywhere. I would like to get out but we can't"; "We are not really supported to go out unless a member of the family comes to take us out"; "I am at the end of my game now, just waiting to go. I would like something to occupy my time but there's not much going on here that I can join in with" and "I don't get to church anymore, it was once very important to me but I have just given up really, not much I can do about it now in here is there?"

A relative said, "I come in sometimes unannounced and always find that there is an activity going on, whether it's singing or dominoes like it was this morning. I must say not always age appropriate but at least it is something".

The activities coordinator was a young apprentice who was very lively and friendly with people. However, due to their lack of experience the activities organised were not always appropriate or pitched at the right level. Activity plans and schedules were not in place to plan activities around people's interests, hobbies and preferences. Although group activities were in progress, many people were not engaged and were sleeping through the morning. The afternoon activities included a karaoke session and this appeared to be too loud for some who were upset by the level of noise. Some people said it was too loud and noisy to play karaoke although two people did enjoy it.

Staff told us they thought the activities coordinator had made a difference and was good at encouraging people to get involved. One staff member said, "[The activities coordinator] has a lovely personality and is very good and patient with people". Staff told us that some people do go out into the community. They gave examples of staff supporting two people who liked to go to a local pub for coffee and another person who liked to go out shopping for clothes. Although this was not the feedback we got from people generally. Staff also told us that one relative sometimes brings a group of children in who they teach ballet to and they dance for people.
An initial assessment had been completed with people before moving in to the service. However, some people's assessments were not complete and provided limited detail. There was no record of people's needs being assessed on an on-going and regular basis to inform accurate care planning. There was conflicting information within the care plans as a result of this. One person's initial assessment said they required full assistance with dressing and their care plan stated that they needed prompting only. Another part of the care plan stated staff needed to put clothes out ready for the person and then provide prompts to encourage them to dress.

Care plans were confusing as there were many different forms of documentation with inconsistent information. Many documents were not completed and remained blank in the care plan file. One person had

a care plan to detail the support they required with their personal care. The care plan stated that they needed the assistance of staff to get up out of bed in the morning. The person was said to require the support of a member of staff to have a bath and they should have this weekly. We found that the person had not had a bath for some time and we did not find evidence that regular baths had been offered or accepted/refused. Records showed the person had a bath twice in March, April and June 2017; once in August; once again on 25 September 2017 and no recording since then up to the day of inspection. We checked the daily records to see if staff had recorded in these records instead, however, no information about bathing was available in the daily records either. This meant that due to inconsistent recording people may not receive the care they required or preferred when they needed it.

One person sometimes had episodes of behaviour that others may find challenging. An ABC chart was in place detailing an incident that occurred on 13 March 2017. ABC charts are an observational tool used to record episodes of behaviour that other people and staff may find challenging. Staff described in the ABC chart how the person had been 'smashing the wardrobe door'. The chart went on to record that the person was feeling nervous and the incident lasted about 10 minutes. The chart was not fully completed, and no instructions were available to guide staff how to complete the chart correctly. Another area within the care plan indicated that when the person was very nervous this acted as a trigger to them becoming upset. No further exploration had been carried out following the incident on 13 March 2017 to find out what had made the person feel nervous at that time. Measures had not been put in place to guide staff how to prevent future occurrences.

Each person had a completed 'This is me' document used as part of a person centred assessment process. It explored the person's past life and the way they may prefer to be approached. It also included the person's likes and dislikes. For example, one person's 'This is me' document said that they liked to eat fish but did not like meat. However, other parts of the person's care plan stated conflicting information around their diet. Some areas stated they were vegetarian and others that they ate some meat. We asked the registered manager who told us the person did eat some meats. The 'This is me' document did not tie in to people's care plans to create a person centred approach based on people's preferences.

The failure to provide care that meets people's assessed needs and preferences is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Each person's daily records were documented in a hardback notebook. Entries were dated but the pages were not numbered. Staff recorded the time of the day when they actually wrote their report rather than when the occurrence or event actually happened. It was therefore not possible to see when people had got up in the morning, what time they ate or went to bed for example. Gaps were noticed in the daily records and were therefore not contemporaneous.

We recommend the provider and registered manager develops a system of recording daily events that provide a contemporaneous record of intervention.

We asked people if they knew how to complain and if their complaints were listened to. People did know who they would speak to if they had a complaint. People told us; "I would just go to the staff or manager or anyone who is around and they are usually prepared to listen"; "I have never been worried about my treatment here and if I was I wouldn't be afraid to say so"; "I complain quite a bit but never get listened to" and "If I was unhappy I would tell my daughter as they are more inclined to take notice of her". One person's relative said, "I have never really needed to complain, nothing too serious to ever complain about". Another relative told us they had needed to raise a complaint and this was not resolved to their satisfaction.

Complaints were not logged in order to monitor themes and outcomes more easily. Some complaints had been made and not recorded. One relative had complained that they had seen another person wearing their loved ones clothes and another complaint had been made about a member of staff. The registered manager told us they had not considered these to be complaints as they were made verbally and dealt with straight away. We saw evidence that action had been taken when the registered manager had addressed these concerns in a staff meeting. However, it was unclear if a satisfactory response had been given to the complainants about the concerns they had raised. A complaint had been made by email in April 2017 and the records of this were kept in the complaints file showing the registered manager had dealt with and responded as detailed in their complaints procedure. The complaints procedure advised that people could take their complaints outside of the organisation to CQC. CQC regulate services and uses complaints information to inform inspection planning. CQC are not responsible for investigating individual complaints. The procedure did not provide details of the Local Government Ombudsman whose remit it is to investigate when people do not feel their complaint has been handled appropriately.

We recommend the provider and registered manager reviews the complaints procedure and systems to take into account all complaints in order to learn lessons and provide a transparent approach to complaints in any format.

Regular meetings were held with people. Minutes of the meetings showed people had the opportunity to take part and be able to express their views of how the service was run. Areas of discussion included; the activities people had enjoyed since the last meeting; activities people would like to try such as contact with animals and trips out; a planned fireworks event, food choices and the quality of meals. People had said at one meeting they were not happy with an external entertainer who had visited the service and it was agreed they would not use them again. There was no evidence of relatives meetings taking place. The relatives we spoke with told us they would welcome relatives meetings or joint meetings with their loved ones. Relatives survey questionnaires had been sent out to people's loved ones and three had been returned. All three responded with good feedback.

Requires Improvement

Is the service well-led?

Our findings

The provider had a range of audits in order to monitor the quality and safety of the service. Regular audits undertaken by either the registered manager or the deputy manager included; the kitchen, infection control, people's weight, wound management, the dining experience, maintenance, activities and training and supervision. In addition, the deputy manager carried out a 'resident care audit' which included a walk around the service, randomly checking people's care files, bedrooms and their appearance; for example, clothes and footwear. The registered manager audited care plans to check they were up to date and completed appropriately. The provider completed a general audit once a month. They spent time chatting to people and staff and walking around the premises to check the cleanliness and improvements required. The provider also randomly chose other areas to look at for example, medicines records and care plan records. Although areas for improvement had often been identified through the audits undertaken, action plans to address the concerns were often not in place and many audits were not dated or the name of who carried out the audit recorded. The service had a stale odour in some areas of the building and at various times through the day. This had been picked up in audits, however remained an issue. One relative told us it was "Often smelly in the home" when they arrived and there was "Always a stale odour throughout".

Quality assurance processes had not been robust enough to successfully recognise the issues we identified in this inspection; the safe management of medicines administration, inconsistent record keeping, person centred care planning that fully met people's needs and preferences, monitoring of people's health and well-being, complaints recording and outcomes, specific training requirements to meet people's specialist needs and the concerns people had about the apparent lack of staff availability at some times of the day.

The failure to have an effective system to identify and make improvements to the quality and safety of the service provided was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were mixed feelings among people using the service about the management and senior team. People told us there were certain members of staff who were not approachable and some thought they were not able to raise this with the management team as there were friendships amongst them. Although people were clear who the management team were some did not feel confident approaching them about everything. One person said, "One person [staff] upsets staff and residents alike but [they are] great friends with those in charge so nothing is done". Other people told us, "It is all pretty ship shape here, might not be the tidiest or the cleanest at all times but it is home" and "We know everyone here and everyone knows us".

Staff thought generally there was an open culture and felt comfortable to raise issues and concerns with the registered manager. One member of staff said, "The manager is always there for you, very approachable. If I have a problem I know I can go to [them]". Another said, "It is definitely well run now". Some staff did comment that there were some things they may not raise as there was a "clickiness" with some staff.

We received mainly positive feedback from health and social care professionals. The comments made included; "The service has improved in the last year"; "I find it easy to talk to staff. They are able to formulate

sensible plans with me and they are easy to get on with" and "In my experience I haven't received any complaints regarding the care from Phoenix, the clients we have placed there seemed to have received the care required".

The registered manager met with all staff regularly each month to provide them with updates and discuss issues that required attention. Staff had the opportunity to raise concerns and suggest areas for improvement. The matters discussed included; training updates; the dress code expected by the registered manager; staff punctuality; communication at handovers and updates on recruitment. Team leaders met with the registered manager to discuss their role and the expectations of them and the staff team.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed a copy of their inspection report in the reception area in a rack which was not noticeable to people and visitors. We spoke to the registered manager about this and they said they would display the ratings poster on the wall to make sure people visiting can see it more easily. Although the provider's website stated 'Current CQC rating requires improvement, new rating awaited', this was not prominently displayed to ensure people and those seeking information about the service could find it easily. We spoke to the registered manager about this who said they would make sure this was rectified.

Registered persons are required to notify CQC about events and incidents such as abuse, serious injuries, Deprivation of Liberty Safeguards (DoLS) authorisations and deaths. The registered manager had notified CQC about important events such as deaths and serious injuries that had occurred since the last inspection.

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 registered manager and provider had failed to plan care and treatment to meet people's needs and preferences

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had failed to ensure prescribed medicines were managed safely

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider failed to operate an effective quality assurance system to ensure the quality and safety of the services provided.