Phoenix Care Homes Limited

Phoenix House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Phoenix House provides accommodation and personal care for up to 24 people who need support with their mental health needs in one adapted building. There were 16 people living at the service at the time of the inspection. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

People's experience of using this service and what we found
People had been harmed or were at risk of harm due to poor risk management. Safeguarding incidents were not always reported or investigated appropriately. Lessons were not learnt, and people continued to be at risk of harm from other people. People continued to receive medicines to control their behaviour in an inconsistent way, people's health needs were not managed safely. There were not enough skilled or trained staff to support people.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Staff were poorly trained and supervised. Due to their lack of knowledge or skills, management of incidents was poor and people had been unnecessarily restricted as a result. People were not empowered to take control over the lives, they were not supported to develop skills and reach their full potential. Working with other healthcare professionals did not always happen leaving people at risk from health needs such as diabetes or constipation.

The provider had failed to act to rectify shortfalls found at previous inspections. This is the seventh consecutive inspection where the service has been rated either requires improvement or inadequate. There has been no sustained improvement. The provider and their representatives have continually failed to provide sufficient oversight of the service and has not responded appropriately to the concerns we have raised.

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

Rating at last inspection and update
The last rating for this service was Inadequate and was placed in special measures (published 20 December 2019). The provider completed an action plan after the last inspection to show what they would do and by when to improve. The service has been inspected seven times since November 2015 and has continued to be rated either Requires Improvement or Inadequate. At this inspection not enough improvement had been made or sustained and the provider was still in breach of regulations.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 7 & 8 October 2019. Breaches of legal requirements were found in safeguarding service users from abuse and improper treatment, safe

care and treatment, staffing, dignity and respect, person-centred care, good governance and notification of other incidents. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe, Effective and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has stayed the same. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Phoenix House on our website at www.cqc.org.uk.

We have found evidence that the provider needs to make improvement. Please see the Safe, Effective and Well-led sections of this full report.

Enforcement
We have identified breaches in relation to Safe care and treatment, Safeguarding service users from abuse and improper treatment, Staffing, Person-centred care, Dignity and respect, Need for consent, Good governance and Notification of other incidents at this inspection. We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of the registration. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Phoenix House

Detailed findings

Background to this inspection

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

Inspection team
This inspection was carried out by two inspectors.

Service and service type
Phoenix House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service did not have a manager registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided. There had been no registered manager in post since July 2019. The current manager had been in post since June 2020 and is currently applying to register.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority, professionals who work with the service and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with seven people about their experience of the care provided. We spoke to six members of staff including the manager, deputy manager, care workers, agency staff and cook. We spoke to two consultants that the provider had employed. We made observations of care to help us understand the experiences of people who chose not to talk with us. We reviewed a range of records. This included four people's care records and medication records. We looked at two staff files in relation to recruitment. A variety of records relating to the management of the service including accident and incident records and daily records were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. The manager sent us additional information after the inspection. This included staff training and supervision schedules, quality assurance and audit information, the statement of purpose, incident records and daily reports.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

At the last inspection on 07 and 08 October 2019 we found issues about how risks were assessed, and the action taken to reduce the risk of harm and abuse. There were concerns about how medicines were administered to support people with their behaviours.

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

Systems and processes to safeguard people from the risk of abuse

- One person said they did not feel safe living at the service, and they were not protected from the risk of harm. In their daily logs an entry stated they had told staff they did not feel safe living at Phoenix House and that it was dangerous. They said they had not slept for 11 nights. As a result of this they were seen by a medical professional and their medicines were reviewed. However, there was no conversation with the person to explore why they did not feel safe.
- We found three body maps of unexplained bruising relating to one person who was at risk from verbal and physical assaults by others. Concerns had not been reported to any external bodies for investigation as required by regulations. We asked the manager to refer this to the local authority safeguarding team. They confirmed they had made a safeguarding alert after our visit.
- There continued to be a poor oversight of safeguarding people's safety and people continued to be at risk of abuse. There were two other incidents we asked the manager to refer to the local authority for investigation. Both incidents had been poorly managed by untrained staff who did not have robust or clear guidance to follow to support people. One person's behaviour management plan instructed staff to 'keep a distance away' and 'call the police and press charges' if they became aggressive. Recordings of incidents were poor and there had been no follow up with the staff to see what lessons could be learned to prevent a repeat of incidents. The manager told us they felt staff had been the trigger to one of the incidents and they could not rely on the incident records to give a clear account of what had happened. Staff did not have the guidance or skills to manage people.

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

Assessing risk, safety monitoring and management; Using medicines safely; Learning lessons when things go wrong

- Risks were not well managed, and people had been harmed as a result. One person's behaviour put them

at risk of being verbally or physically abused by other people. There was an incident in April 2020 where the person had not been consistently monitored by staff and as a result they had been assaulted by another person. Although a positive behaviour management plan had been implemented this lacked specific information about how staff could use techniques to support the person. The actions staff should take to support the person in the guidance was not followed by staff. No additional measures had been implemented following the incident to reduce the risk of the person being harmed again. Daily reports stated the person was in a distressed state which put them at risk or harm from other people. Staff had not taken proactive action to protect the person or support them. There had been another incident in May 2020 where the person had been verbally abused.

● Other people had behaviours that could be challenging to manage. Patterns to people's behaviours and incidents had not always been analysed to see if there were specific things that triggered a person's anxiety.

● Management of people's health was poor and left people at risk of harm. For example, several people were at risk of constipation. One person's care plan stated bowel monitoring charts should be completed. Charts were inconsistently recorded with long gaps between recorded bowel movements. The care plan gave specific times when further action was necessary, for example administering PRN medicine or contacting the persons GP for further support. There were many occasions when the person had not had a bowel movement for days, but no action had been taken leaving the person at risk. The persons elimination care plan stated constipation could cause discomfort, distress and increased anxiety. No link had been considered between the possibility of constipation and the increased number of incidents of behaviour the person displayed.

● People were not always supported to maintain their hydration by monitoring their fluid intake. For example, whilst we saw fluid charts in place for some people, one person's care plan said they should aim to drink 1500ml of fluid a day, but this was not being monitored. Another person was prone to urinary tract infections and at times could drink fluids excessively. Some people were diabetic but information for staff about how to support them was lacking or missing. Staff did not know how to support people with their diabetes or when they should take further action if people were to become unwell.

● Medicines were poorly managed. At our last inspection we found poor practice around administering a person's as and when required medicine (PRN) to help them manage their behaviours and anxieties. Poor practice continued. Staff did not have any specific guidance to understand when PRN should be administered. Between April and June 2020, the person had episodes of behaviour. Sometimes they were given PRN other times they were not. The approach to behaviour management was inconsistent and would depend on which staff were on shift if the person was administered PRN medicine. On occasions the person had displayed a certain behaviour and the PRN medicine was given. On other occasions when the same behaviour was displayed the PRN medicine was not given. On one occasion the person had received PRN for no recorded reason. On four other occasions daily records stated they had received PRN medicine, but this had not been recorded on the Medicine Administration Records (MAR).

● Medicine records were poorly maintained and sometimes inaccurate. Audits had not identified errors and no investigation into errors were made. In a person's daily records, it stated they had been given medicines at a certain time, but the MAR chart stated a different time. Some MAR charts were not dated so it could not be identified accurately when medicine was given. Following the inspection, the provider told us they had updated their protocols to improve guidance on as and when medicines.

● The provider has not learnt lessons from previous inspections and had not made improvements to sustain and embed good practice. At this inspection, we have identified the same concerns we had reported on at our last inspection. The provider has not learnt or implemented measures to prevent repeated concerns.

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

● We requested information to be sent after the inspection about how the environment was maintained safely, which we received. Some additional measures, since the last inspection, had been implemented to keep people safe. For example, we observed people who smoked being supported by staff with equipment to reduce the risk of fire.

Staffing and recruitment

● There were insufficient numbers of skilled, suitably qualified, experienced and competent staff deployed to meet people's needs. This had an impact on the care and treatment people received. The provider had not ensured staff were trained, skilled, experienced or competent.

● Some people received additional funding for 1-1 hours due to their complex mental health needs: none of these hours were delivered. This left people without the right support and at risk. One person had been assaulted by another person, causing them harm. Processes had not been put in place to ensure appropriate staff support was in place for either person. Both people were funded for 1-1 support due to their complex mental health condition. Neither received the 1-1 support they were assessed as needing.

●The business manager had used a dependency tool to determine staffing levels. We asked the manager how they had calculated the number of staff on duty remained correct: They did not know. They said they had continued to use the same number of staff that were in place when they had taken up the position. The local authority commissioned one to one hours for several people. This was not reflected in staffing levels on the day or reflected in the dependency tool.

● The provider had not ensured agency staff had the right skills or competencies to support people with their needs. The manager said they had been unable to obtain some agency staff training records so did not know if they had been trained to support people with their mental health needs.

The provider had failed to ensure there were enough trained and competent staff to support people. This is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff records showed that new staff were recruited safely. Gaps in employment history were explored and references obtained before new staff work alone with people. Proof of identification was checked. Disclosure and Barring service (DBS) checks had been completed which helped prevent unsuitable staff from working with people.

Preventing and controlling infection

● Current government guidelines were being followed to maintain good infection control practices because of the increased risk during the pandemic. We observed staff wearing appropriate personal protective clothing throughout our visit, three separate dining areas had been created to encourage social distancing.

Inadequate

Is the service effective?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

At the last inspection on 07 and 08 October 2019 we found issues around unnecessary restrictions placed on people, staff training and how people were supported with their health.

At this inspection we found continued issues around how people consented to their care and treatment, staff training and competence and how people were supported with their health.

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

- People's health was not managed safely. Staff did not have good knowledge around specific health conditions people may have such as constipation or diabetes. The monitoring of people's health was not robust. Care plans lacked information for staff to refer to, to help them support people with health conditions. Staff had not followed the information that was available to manage health conditions. This combined with poor staff training and assessment of competencies placed people at risk of their health needs not being recognised or met.
- Staff did not have the right skills to recognise the signs and symptoms when people had health issues. Staff were supposed to check the blood sugar levels of a person with diabetes twice a day. This was not consistently completed and records of this were incomplete. When the person's blood sugar levels were too high or low medical advice had not been sought leaving the person at risk. Staff did not know what action they should take if concerns were identified. We asked one staff member why they recorded the persons sugar levels and they told us they did not know. After the inspection we were sent information from the manager to say the GP had been contacted for other people with diabetes so guidance could be given. This meant until our inspection other people had been at risk.
- Health care plans to support people manage their mental health conditions were poor. For example, the manager told us one person had become increasingly distressed at a certain time of day. The care plan did not give clear guidance for staff to follow to support the person in an effective or consistent way. The manager told us the way staff were supporting the person was not working but no action had been taken to improve this. Ineffective health care plans combined with poor staff training in mental health placed people at risk of their health needs not being recognised or met. After the inspection the provider sent us records to demonstrate they had implemented positive behaviour management plans. We will check these have been adhered to at our next inspection.

The provider had failed to ensure people's health was well managed. This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

● Staff did not have the right skills or training to support people with their individual needs. Senior staff such as team leaders did not have the skills, knowledge or competency to support or guide other staff.

● The majority of training was online in areas such as infection control, health and safety, fire safety and food hygiene. Staff did not receive sufficient training in managing people's behaviours or complex mental health conditions. The manager told us they had asked the provider for bespoke mental health training for the staff but this had not been arranged. Although most staff had completed mental health awareness training the provider did not have systems in place to assess staff competency or knowledge in supporting people with their mental health needs following this training. Following the inspection, the provider told us they were in the process of checking staff competencies to ensure they were safe to work with people, this was ongoing.

● A competency assessment planner had been implemented but showed very few staff including agency staff had been competency checked in areas such as safeguarding, infection control, medicine, record keeping or nutrition and hydration. Out of 10 permanent staff and nine agency staff most had only been competency checked in hand hygiene.

● Staff had not received regular supervision. Out of 10 staff seven had received one supervision and three staff had received two in 2020. This meant that staff did not receive regular feedback on their performance or have an opportunity to raise issues regarding the service or their development. Eight staff had received an appraisal. The consultant had introduced competency based supervisions for staff which they said was a work in progress. However, Staff had not received regular supervision before and during the COVID-19 pandemic. Out of 10, staff seven had received one supervision and three staff had received two in 2020. This meant that staff did not receive regular feedback on their performance or have an opportunity to raise issues regarding the service or their development. Eight staff had received an appraisal.

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

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

● People were not treated in an inclusive or dignified way. During lunch, a trolley was placed in front of the kitchen door and people's names were called by the cook to go to the trolley and collect their meal. Lunch time did not feel like a relaxed, enjoyable experience. Some people could display behaviours that could be challenging at meal times. This had not been addressed effectively and created a tense atmosphere. Some people chose to eat their meals in different communal areas of the service or in their bedrooms.

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

● People who required support with their meals were observed by staff and encouraged to eat slowly so they did not choke. People told us they thought the food was okay and they were offered a choice of meals. People were not supported to prepare their meals but could go to the small kitchen to make their own drinks.

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

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

possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

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

● People were being unnecessarily restricted because staff did not have the knowledge, skills or guidance to support people with their individual needs or behaviours. There had been an incident where a person was locked out of the service by staff who did not know how to support them effectively. Another person had been physically removed from the kitchen because staff did not know how to support them with their behaviour.
● Staff were not supportive when people were making decisions about their future. One person had expressed a wish to take up a college course or work placement. They had not been supported with their ambition to increase the control they had over their life. Following the inspection, the provider told us the person was being supported to look at other opportunities.
● Some people were subject to a DoLS which had been authorised. Other DoLS had been applied for and were awaiting assessment. Nobody had any conditions attached to their DoLS at the time of our visit. Other people could make their own decisions. Many people under a DoLS were legally prevented from leaving the service unaccompanied. The service was remote and isolated.

The provider has failed to ensure that staff were working within the principles of the Mental Capacity Act (2005). This was a breach of Regulation 11 of the Health and Social Care Act 2008(Regulated Activities) Regulation 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Adapting service, design, decoration to meet people's needs
● Assessment of people's needs did not result in robust risk management or guidance for staff to follow to support people. Nobody had been admitted to the service since our last inspection. We were told care plans were currently under review and a 'resident of the day' system had recently been implemented. The manager planned to use the resident of the day to focus on reviewing individual care plans and activities. At the time of the inspection this had not been fully implemented.
● There were assessments around falls, choking risk, and nutrition. The assessments had not captured details of people's mental health needs, or what support was needed regarding this.
● For the past six inspections we have identified concerns with how peoples care is assessed, planned and documented. Care plans have not been personalised and have lacked information for staff to follow to support people with their individual needs. There has been no sustained improvement and as a result people have not received care centred around their needs. They have not been supported with their personal goals or been involved in their care planning in a meaningful way.
● The service was isolated with poor transport links. People who were able to go out independently could go out but people who required support when going out were restricted. The service had one vehicle people sometimes used or they used taxis if they could afford it. People were not supported with resources or opportunities to integrate into the wider community to have more engagement to build a wider social

network.

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

● The service provides accommodation for people on three floors, which could be accessed by a passenger lift. There were accessible garden areas for people to enjoy. People decorated their rooms in their own way.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At the last inspection on 07 and 08 October 2019 we found significant concerns regarding the providers oversight of the service. The provider had not ensured the service was well led, and people had not received safe care and support.

At this inspection we found no improvement. The service continued to be inadequately led and people continued to receive poor support and care leaving them at risk of harm.

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

- This is the seventh consecutive inspection where the service has been rated either requires improvement or inadequate. There has been no sustained improvement. The provider and their representatives have continually failed to provide sufficient oversight of the service and has not responded appropriately to the concerns we have raised. This has had an impact on people's health, safety and welfare.
- There was no clear leadership at the service. We asked what the purpose of the home was according to the statement of purpose (A statement of purpose outlines what is provided to people at registered services). The management team said they did not know, the manager said, "It's difficult to say if we are trying to provide rehabilitation or a home for life, it's still not defined".
- The provider had appointed a new manager since our last inspection who had started working at the service in June 2020. They were in the process of registering with CQC. There continued to be poor accountability, staff were not clear about their roles or responsibilities. For example, we continued to find issues around the recording and reporting of incidents.
- The provider did not ensure people were safe or that concerns were dealt with effectively and measures implemented to reduce repeated incidents. The provider was not proactive and had not improved the standards of the service. The lack of action from the provider had a direct impact on people who had been harmed or were at risk of harm. The provider had not taken their responsibility seriously which has meant the people living at the service had a poor quality of life with limited opportunities.
- Following our inspection in October 2019 the provider had used different external consultants to audit and monitor the service. Their input had not been effective and had not brought about change and improved outcomes for people.

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

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● The provider had failed to promote a positive culture and had failed to identify the shortfalls at the service. Some staff told us they felt unable to challenge management about some of the decisions that were made. The culture at the service did not empower staff or people.

● People continued to be unsupported to engage meaningfully with wider society. We have reported previously about the lack of opportunity people had to gain more independence, develop skills and reach their potential. People were not supported to maintain any previously developed skills. The provider had continuously failed to provide people with a service which allows them to thrive.

●There was poor communication between staff and people were not supported in a positive, inclusive or empowering way. For example, a person's daily records had entries which were not dignified or appropriate such as, 'Afternoon, (person) is good', '(Person) has been good, but sometimes not', and 'Afternoon (person) screamed too much'. Staff continued to lack confidence or training to challenge poor practice.

● The provider gave us verbal and written assurances following our previous inspection in October 2019 that significant improvement had been made at the service. We found no improvement and people have suffered as a result. The provider had not identified any of the concerns we found during this inspection. Their processes to audit the service are inadequate, they did not learn from mistakes.

● The provider has not demonstrated a commitment to improve the service people received. They had not addressed the poor culture or provided any leadership or role modelling for staff. There have been a number of different managers over the last few years. The provider has not supported staff or people through transitions. One person we spoke to asked where the previous manager had gone. We told them we did not know, they said, "I miss (previous manager), they would come and make a coffee with you and talk".

● The manager told us they were working hard to improve the staff culture and team but there was a lot of work to do and it would take time to embed.

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

● The provider had started to implement support for some people to become more independent. For example, some people where supported to do on line shopping and some had begun to bake with staff.

The provider had not ensured the required notifications had been sent to the local authority or CQC as required. Three safeguarding incidents had not been notified to the local authority or CQC regarding incidents of bruising, when a person had been locked out of the service by staff and when a staff member physically removed a person from the kitchen.

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