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 caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Phoenix House provides accommodation and personal care for up to 24 people who need support with their mental health needs. There were 19 people living at the service at the time of the inspection. The service is situated in its own extensive grounds and gardens in the rural village of Northbourne, which is close to the seafront towns of Deal and Sandwich.

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

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

The last inspection was carried out on 13 December 2016 when we found continued breaches of the regulations from our inspection on 3 November 2015. The service was rated 'Requires Improvement' and 'Inadequate' in the 'well-led' domain. The provider sent an action plan to CQC in February 2017 with timescales stating they would be compliant with the regulations by March 2017. At this inspection the provider had failed to comply with their action plan and there were continued breaches of the regulations relating to safe care and treatment, treating people with dignity respect that promoted their independence and autonomy, person centred care and good governance. There were also new breaches identified relating to need for consent, safeguarding people from abuse and proper treatment, staffing, not notifying the relevant bodies when incidents occurred at the service and complaints.

The service did not have a registered manager in post. 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 and associated Regulations about how the service is run.

The registered manager had left in March 2017. We contacted to the registered provider about this before the inspection. A new manager had been appointed in April 2017 but they left in June 2017. Another manager had been employed and they were due to start work at the service on 10 July 2017. In the meantime the provider's business manager was supporting the service but was not at the service every day. The deputy manager of the provider's other service was supporting the service. When we returned for the second day of our inspection we met the new manager.

The provider had not taken appropriate steps to ensure they had oversight and scrutiny to monitor and support the service. There was a lack of continuity in the leadership and management of the service, which had impacted on people, staff and the quality of the care provided. There were quality assurance systems in place, which included reviewing and updating care plans, audits, health and safety checks, but these had

not been consistently undertaken. Records were not suitably detailed or accurately maintained. Previous breaches of regulations had not been addressed and the breaches continued.

Some people told us they did not feel safe at the service. People were not fully protected from harm and abuse. Incidents had occurred when people and staff had been hurt. The staff had not followed safeguarding protocols and incidences had not been reported to out-side agencies. Referrals had not been made to the local safeguarding authority when safeguarding incidents had happened. The staff had not informed CQC of important events that occurred at the service, in line with current legislation.

Potential risks to people were identified, like diabetes, choking and when people had behaviours that could be challenging. Full guidance on how to safely manage the associated risks was not always available. There had been occasions when people displayed behaviours that may challenge. There were no step by step guidelines in place to explain to staff how to support people in a way that suited them best. Staff had given inconsistent support which left people at risk of not receiving the support they needed to keep them as safe as possible. Some accidents and incidents had been recorded but some had not. There was no analysis or oversight of the accidents and incidents. Triggers, patterns and interventions had not been identified to try and reduce the risk of re-occurrence.

Generic emergency plans were in place so if an emergency happened, like a fire, the staff knew what to do. However, personal emergency evacuation plans (PEEPs) were still not adequate and did not contain information about people's individual needs during an emergency evacuation. This was identified as breach of the regulations at the last inspection and continued to be a breach at this inspection.

People were not fully supported effectively with their health care needs. There had been delays in accessing health care specialists when they were needed. People's medicines were not always managed safely. People did received their medicines when they needed them. When people needed 'as and when' medicines there was not always guidance in place and hand written entries on medicine records had not been countersigned. When errors had occurred they were not investigated to prevent re-occurrence.

Care plans did not contain all the information needed to make sure people received the care and support that they needed. The process of reviewing and updating people's care plans had fallen behind due to the lack of leadership and management. Some care plans had been reviewed but people had not been fully involved in reviewing their care plans to have a say about how they wanted to receive their care and support. This was identified as breach of the regulations at the last inspection and continues to be a breach at this inspection.

People were not always empowered to have as much control and independence as possible with aspects of their lives. People were not always treated with dignity and respect that promoted their independence and autonomy. This was identified as breach of the regulations at the last inspection and continues to be a breach at this inspection.

People told us they knew how to complain. However, we were not confident that their complaints would be taken seriously and the necessary action taken.

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

capacity to make complex decisions, which were usually for medical procedures, there was no evidence that best interest meetings had been held.

There was a task orientated culture at the service, staff were busy doing different chores rather than spending time with people. Staff did not have the time to spend with people to give them person-centred care. People told us that they were bored and had nothing to do. They said they were not going out as much as they used to and missed going places and doing different activities. Staff said that more activities were needed for people. Some people were able to go out daily and do what they wanted to in the local area.

People had their needs met by sufficient numbers of staff. The provider had recently employed new staff and when there were shortfalls agency staff were employed. However, we were told there had been times when there had not been enough staff. People and staff told us that sometimes planned activities were cancelled as there was not enough staff available. Staff had not received the training and supervision necessary to complete their roles effectively.

Most staff knew people and their preferences and life histories. Staff were recruited safely. Contact with people's family and friends, who were important to them, was well supported by staff.

No new people had moved to the service since the last inspection but there were procedures in place to assess people prior to them coming to live at Phoenix House.

People were offered and received a balanced and healthy diet.

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

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

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

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not fully protected from harm and abuse. Incidents of abuse had not been reported to out-side agencies.
Risks to people were assessed but there was not always full guidance to make sure all staff knew what action to take to keep people as safe as possible.

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

The management of medicines had improved but there was no guidance in place for when people needed medicines for when they were restless or agitated.

There were enough staff on duty to make sure people received the care and support they needed. Staff were recruited safely and the provider's recruitment policy was followed.

Is the service effective?

Inadequate

The service was not effective.

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

Staff did not receive the supervision and support they needed to carry out their roles effectively.

People were not fully supported with their health care needs.

The provider had not applied for Deprivation of Liberty Safeguard authorisations when people who lacked capacity to consent, had their liberty restricted, as required by law.

People and their representatives were not fully involved in making decisions about their care and support.

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

Is the service caring?

Inadequate

The service was not caring.

People were not always treated with dignity and respect that promoted their independence and autonomy. People's privacy was not always supported

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

People were not supported to be an independent as they could be.

People's records were stored securely to protect their confidentiality.

Is the service responsive?

Inadequate

The service was not responsive.

People did not always receive the care and support they needed to meet their individual needs.

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

There was a complaints procedure in place, However, internal complaints made by people and staff had not always been investigated and responded to fully.

Is the service well-led?

Inadequate

The service was not well led.

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

There was a lack of continuity in the management of the service, which had impacted on people, staff and the service provided. There was no registered manager.

Care staff were aware of their role and responsibilities but the management and governance was not effective.

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

maintained.

Phoenix House

Detailed findings

Background to this inspection

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

This inspection took place on 7 July 2017 and was unannounced. The inspection was carried out by three inspectors. On 11 July 2017 one inspector and an inspection manager met with the provider and the new manager at Phoenix House. We brought this inspection forward as serious concerns had been raised to the Care Quality Commission.

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

We met most of the people living at the service and had conversations with ten of them. We spoke with four members of staff, one who was agency staff, the deputy manager of the provider's other service (who covering at Phoenix House in the absence of a manager) the business manager, the provider and the new manager. We also spoke with three visiting professionals at the inspection. Before and after the inspection the inspection we spoke with two professionals who had contact with the service.

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

We last inspected this service on 13 December 2016 when breaches in the regulations were found.

Inadequate

Is the service safe?

Our findings

Some people said they did not feel safe living at Phoenix House. They told us it was frightening when other people got angry and upset with each other. People said they did not like people shouting and sometimes hitting each other. One person said, "I do not want to be here I want to go somewhere else. I don't feel safe". They would not elaborate any further. Other people said that they did feel safe, they said that the staff looked after them and if they were worried about anything the staff would listen. People told us, "I am as safe here as I would be anywhere else" and "I do feel safe. It's my home".

Professionals who had involvement and contact with the service told us that they had concerns about people's safety at Phoenix House. Care managers from the local authority were in the process of meeting with people to make sure they were receiving safe care and support.

People were not fully protected from harm and abuse. Incidents had occurred when people and staff had been hurt. The staff had not followed safeguarding protocols and procedures. Incidents had not been reported appropriately including to out-side agencies. Referrals had not been made to the local safeguarding authority when safeguarding incidents had happened so they were not aware of them. The local authority had not had been given the opportunity to investigate to make sure that people were protected and safe. The staff had recorded that the incidents or accidents had happened but there was no information about what the trigger may have been and what action they had taken to make sure people were protected. Staff were trying to manage each incident but inconsistent support from staff meant that incidents continued and people continued to be at risk of harm and improper treatment.

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

At our last inspection in December 2016 and the inspection before in November 2015 there was a risk that people's safety in the event of a fire may be compromised. At this inspection the necessary improvements had not been made. Each person had an individual personal emergency evacuation plan (PEEP). A PEEP sets out the specific physical and communication needs of each person to ensure they could be evacuated safely from the service in the event of an emergency. These were not completed consistently. We looked at 19 PEEPs and ten of these did not have the person's photograph or room number on. None of the PEEPs were dated, signed or reviewed and there was a risk they were not up to date.

Some people living at Phoenix smoked and there had been two incidents of fire in the building within the last six months. Records of a staff meeting dated 5 June 2017 noted there had been other occasions when the fire alarm had been set off by a person striking matches in their bedroom. The provider had responded saying they would speak to the person 'and make them aware of the risk to themselves and others'. Staff had also raised concerns that two people were sharing matches.

Staff had not all completed training about fire safety so there was a risk they would not know how to evacuate people safely if there was a fire . Records showed only three staff had up to date training in this

area. The provider's 'environmental risk assessment action plan' noted, 'All staff are to be trained in fire safety. Any staff that require training are to be put onto the next available course. To discuss fire safety procedures at the next team meeting'. Action had not been taken to complete this. Due to our concerns we made another referral to the Kent Fire and Rescue Service and asked the provider to take immediate action to ensure people would be safe in the event of a fire.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The building was fitted with fire detection and alarm systems. Regular checks were carried out on the fire alarms and other fire equipment to make sure it was working. Special precautions had been put in place when increased risks to people had been identified, like fire retardant sheets, extra fire extinguishers and extra staff checks. Staff and people were involved in monthly fire evacuation drills, this included one at night as advised by the fire officer. Regular maintenance checks were made on systems like the boiler, the fridge and the electrics and gas supply. Equipment had been serviced and regularly checked to make sure it was in good working order.

Risks to people had been identified but the guidance on how risks should be managed varied from person to person. Some people at times became upset or agitated and could exhibit behaviours that challenged. Some risk assessments did not give clear guidance to explain to staff how they should support people consistently in a way that suited them best. For example, one risk assessment stated, 'that a person may display aggression to others'. To minimise the risk the guidance was to, 'monitor person behaviour on a regular basis. Staff to intervene if person becoming upset or aggressive'. Another risk assessment stated 'use de-escalation and verbal re-direction'. There was no information or guidance about what type of intervention may be needed and at what point it should be initiated. There was no guidance on what the de-escalation and verbal –re-direction should be. Other risk assessments had written guidance, 'be firm with [the person]', 'remove from premises'. One risk assessment stated, 'If person becomes aggressive, contact their psychiatrist'. It did not say what action staff needed to take to make sure people were immediately kept safe. Some risk assessments had not been signed or dated and there was no record that people had been involved in discussions about risk or had agreed to any sanctions.

Some staff were able to say how they would support people in these situations but other staff were unsure. There were some new staff and agency staff so there was a risk that staff would not take the appropriate action to keep risks to a minimum as there was insufficient guidance.

Some people were at risk of choking, there was guidance and direction about what staff needed to do to prevent people from choking, like pureeing their food and observing them when eating. However, there was no guidance in place about what action staff should take if people did actually start to choke.

When accident and incidents had occurred at the service these had been recorded but there was no analysis in place to identified trends and patterns to try and prevent them happening again in the future. This was especially related to behavioural incidents but we also found that medicines errors had occurred and these had not been investigated to try and find out what went wrong and no action had been taken to prevent their re-occurrence.

Visiting professionals said that they requested staff to report any behavioural incidences relating to one person to them. The staff had failed to do this.

The provider did not have sufficient guidance in place to safely support people with their behaviour. Risks were not reduced and mitigated. This was a breach of Regulation 12 of the Health and Social Care Act 2008

Other risks had been minimised since the last inspection. Risk assessments were now in place for people who had diabetes. There was clear guidance about what action the staff should take if a person's condition became unstable and their blood sugar became too high or too low and what signs they should look for.

Each person had an individual medicine cabinet in their bedroom so that they received their medicines in private and in a way they preferred. People said they received their medicines safely and on time. Some people were given medicines on a 'when required basis', these were medicines for pain like paracetamol or medicines to help people remain calm. People were asked by staff if they were in pain and if they needed any 'pain relief'. There was guidance for each person who needed 'when required medicines' for pain and staff checked that the pain relief medicines were working effectively. For other 'when required' medicines including medicine to reduce anxiety, the guidance did not fully explain when and why the person should receive the medicine. There was a risk that people may receive their 'when required' medicines inconsistently. The effects of the medicines were monitored to see if they were working for the person. If they were not effective this was reported to the person's doctor and further advice was sought.

The medicines given to people were accurately recorded. Hand written entries of medicines on the Medication Administration Record charts had not always been consistently countersigned to confirm that the information was correct and to reduce the risk of errors. At the last inspection we highlighted these shortfalls a made a recommendation requiring improvement. At this inspection there were still the same shortfalls. We also found that a person's emergency medicines for their diabetes was out of date, so it may not have been effective if the person had needed it to be administered. Staff had not been regularly checked and observed to make sure they were giving people their medicines safely. When medicines errors had occurred the staff had taken immediate action and contacted peoples doctors for advice and had acted on the advice given. However there was no further analyse or investigation as to why the errors had occurred to prevent them happening again.

The provider had not ensured the proper and safe management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008

All medicines were stored securely and staff had received training in medicine administration, which was refreshed every year. Medicines which required being stored in cooler temperatures were stored in a fridge. Temperatures were recorded in all the rooms were medicines were stored and these were within the recommended ranges. Some people were prescribed medicines which required regular and close monitoring by having regular blood tests. People were supported to attend planned appointments to have their blood tests.

Bottles of medicines were dated when they were opened so staff were aware that these items had a shorter shelf life than other medicines, and this enabled them to check when they were going
out of date.

At the last inspection the provider had not ensured that all the information and safety checks required before new members of staff started work were in place. At this inspection improvements had been made. Recruitment checks were completed to make sure staff were honest, trustworthy and reliable to work with people. Information had been requested about staff's employment history and any gaps in people's employment were discussed at interview. Two references were obtained, including from the last employer, and proof of identity and right to work in the UK was provided, when necessary. Staff told us checks were

carried out before they started working at the service. Disclosure and Barring Service (DBS) criminal record checks were completed before staff started working at the service. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Staff duty rotas showed there were consistent numbers of staff on duty during the day and night. There was generally enough staff on duty to meet people's needs and keep them safe. However, the provider relied on agency staff and people were unable to go out as often as they would like because there was not always enough staff, who knew them well, to support them to do so. People told us they would like to go out more. One member of staff commented, "We are understaffed with permanent staff. This means we can't take people out as much as we would like to". Another staff member said, "We sometimes take people out in the minibus to McDonalds drive through but that isn't really people going out". The business manager had arranged additional staff cover from another service owned by the provider as a short term measure whilst they recruited new staff.

Inadequate

Is the service effective?

Our findings

Staff said that they supported each other on a day to day basis and that the staff worked well together. They said due to the lack of management presence they had to get on as 'best they could'.

Visiting professionals told us that they did not think the staff were skilled enough to look after the complex people at Phoenix House. They said that people did not get consistent support because the staff did understand what they needed to do. One professional told us that one person had become deskilled since moving into Phoenix House because staff did not have the skills to support them to develop. Visiting professionals also raised concerns about communicating with staff. Some of the staff had English as their second language and professionals said they sometimes thought staff did not understand what was being asked of them. We spoke with the business manager about the language barriers, and they told us, "Two staff were helped by the previous registered manager with extra training and improved their English. Additional time is given in training to allow for this. Nothing has been brought to my attention regarding communication. I have more of a concern about writing than speaking". Staff said "The communication could be improved by more meetings, reading the communications book and [dealing with] language barriers".

Staff did not support people in a meaningful way. They did not encourage people to be involved. Staff did not understand about peoples complex needs and how best to support them. Staff told us that they had not received safeguarding training, challenging behaviour or mental capacity training. Records confirmed that this was the case.

People did not receive effective care and support from staff trained in their roles. Staff completed a basic induction when they started working at the service and new staff completed the Care Certificate. The Care Certificate is an identified set of standards that social care workers adhere to in their daily working life. New staff shadowed experienced staff to get to know people, their preferences and routines. Agency staff had a brief induction to the service when they began a shift.

The records of completed training were held in different places and there was no overview of staff training to identify when staff were due to complete refresher training and to make sure staff were up to date with best practice guidelines. The management were unable to tell us whether staff on each shift had the right mix of skills, experience and knowledge to provide effective care and support. For example, of the 12 staff shown on the provider's training system, only one had completed training regarding behaviours that may challenge others. Two other staff had started the training in November 2016 but it was not completed. Only six staff had completed training about mental health and the people staff were caring and supporting had complex and challenging mental health needs. There had been incidents when people had become distressed and caused harm to themselves or others including staff and incidents reports showed that different staff were using different approaches so there was a lack of consistent support.

The business manager had identified that staff were behind with refreshing some of their training and was taking action to remedy this. They told us that staff had been given until 16 July 2017 to complete their on-

line training. Staff confirmed that there was training that was overdue.

Staff had not received regular mentoring through one to one supervision. Not all staff had had an annual appraisal to set goals and objectives and to discuss their personal development. Staff competency in topics, such as medicines, moving people safely and staff interactions had not been completed to make sure staff were supporting people safely and effectively. Staff had no direction or guidance about how to best undertake their roles. Staff were not supported by the provider and were trying to manage day to day.

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

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

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application 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. The provider had not followed the principles of the MCA. People had not had their mental capacity assessed and staff had not considered the least restrictive option was used when people were restricted. Some people had received medical treatment. Their capacity had not been assessed to identify if people understood the treatment and were able to consent to it. The treatment had been carried out without regard to the person's wishes.

The staff had informally considered people's mental capacity to make day to day decisions but there was little information about this in people's care plans. There were no mental capacity assessments in place for the majority of people to determine whether people had capacity or not to make decisions. When people lacked capacity to give consent to there was no mental capacity assessment available and no best interest decision making record to show that decision had been made in the person's best interest. Information was not always provided in a way that people could understand to help them make decision.

We found that one person, who was being restricted, had an approved DoLS authorisation but this had expired in May 2017 and an application to renew this had not been made. The provider had not informed the Care Quality Commission that the DoLS was in place, as required by law. There were other people with enduring mental needs who were unable to consent to their liberty being restricted and DoLS applications had not been considered.' People's rights were not upheld and the imposed restrictions were unlawful.

The staff had not completed MCA and DoLS training and did not have an understanding of when it would be necessary to make a DoLS application or what it involved.

The provider has failed to ensure that staff were working within the principles of the Mental Capacity Act (2005). Applications to deprive people of their liberty had not been applied for when needed. This was a breach of Regulation 11 of the Health and Social Care Act 2008(Regulated Activities) Regulation 2014.

In some cases, people's decisions had been respected. A person, who had full capacity, had made a decision not to visit the dentist. This decision had been respected and was recorded in their care records.

People did not always receive the support they needed to manage their health care needs. Visiting professionals said that they found it difficult to communicate with staff who had English as a second language. They felt that staff did not sometimes understand what was asked of them. They said that the information that staff gave them was often contradictory.

A visiting professional told us that one person had seen the psychiatrist six weeks ago. They had attended the appointment with a member of staff. The psychiatrist had made a decision to reduce the person's medicine and said they would write to the person's own GP to amend their prescription. The staff failed to follow this up with the GP and had not contacted the GP's surgery to find out if the letter had arrived. The visiting professional prompted staff to contact the GP. The person's medicines were eventually reduced but there was a significant delay.

Another person had had a fall and was in pain. The GP had prescribed them pain killers. The person continued to experience varying levels of pain over the next 12 days. The daily records showed that the person was given pain relief but there nothing written to indicate whether or not this was effective. On the twelfth day following the fall the daily notes stated the person was still in a lot of pain. The staff had not contacted the person's GP to review the situation. The person had suffered another fall and was taken to hospital. We informed the local safeguarding lead about these concerns.

The provider had failed to ensure that people received safe support with their healthcare needs. This was a breach of Regulation 12 of the Health and Social Care Act 2008.

On other occasions people were supported to go to the GP, dentist and optician; appointments had been made for blood tests when people were on special drugs where they needed to have their blood levels monitored. Most people had regular appointments with the local mental health teams.

People told us the food was good and that they enjoyed their meals. They said there was always a choice. If people did not like the choices then they could have something else. The cook had talked with people about the food that they liked and preferred.

The lunchtime meal was a social occasion. Some people sat together and chatted. Other people choose to eat their meals in the conservatory or in one of the other communal rooms. There was a relaxed and friendly atmosphere. People were supported and encouraged to eat a healthy and nutritious diet. People were able to have their meals when they wanted them.

Some people had tea and coffee making facilities in their rooms so they could be more autonomous and independent. Sometimes people chose to eat out in local restaurants and cafés.

The cook said that people were now making their own cups of tea at breakfast and tea-time with support from staff. People were involved in planning menus and this was discussed at residents meetings. People were not fully involved in preparing their meals but had started making sandwiches, cakes and puddings in the afternoons.

Special diets were prepared for people. Softened or supplement foods were provided when it was necessary. When people were not eating or drinking enough their diet and fluids were recorded and monitored and action was taken if any concerns were identified. The meals were well presented with ample

portions. Staff were sensitive and discreet when they supported people to eat. They supported people to eat at their own pace and to enjoy the meal.

Inadequate

Is the service caring?

Our findings

People said, "The staff are alright here". "My best friend is a member of staff, they chat with me". "It's not bad here. The staff like to oblige" and "They (the staff) are all friendly people"

Staff said, "We are enthusiastic and want the best for people" and "I love working here. The atmosphere is good. Residents and staff get on well".

Whilst we observed staff being kind and respectful towards people, people were not always at the centre because staff sometimes focussed on tasks rather than on people as individuals. Staff said we they had to do tasks at certain times, like tidying bedrooms, doing the laundry, making sure people had a bath on a certain day at a certain time. On two occasions we saw the staff group sitting around a table together writing daily records, people were left unattended at these times. At other times staff had the opportunity to engage and interact with people; instead they stood around watching people. People were not always fully considered and were not treated with respect and dignity.

People were not always treated with respect and their privacy and dignity was sometimes compromised. A visiting professional had witnessed an incident when a staff member was supporting someone in the bathroom, the house phone had rung and the staff came out of the bathroom leaving the door open. The person they were supporting was left naked on a shower chair for everyone to see.

Some staff spoke in a disrespectful way about people. One staff member, when talking about people said, "People here can be lazy at times. They won't do things for themselves. They won't make a cup of tea". Staff did not show empathy and understanding of people's mental health needs and the impact this might have on their abilities.

People were not always supported to be as independent as they could be. The provider stated in their statement of purpose that the service offered a rehabilitation service for people. However, we found that opportunities for people to be rehabilitated and develop their skills were limited. A visiting professional told us about one person who used to have a lot of skills prior to living at Phoenix House. They used to go out on their own, get a bus, help prepare meals but now they did not do these things. They had not received the consistent approach that they needed and had become de-skilled.

Staff did not include and actively encourage people to take part the day to day running of the service. Staff did for people rather than with people. Staff did people's laundry, they tidied their rooms and they served people drinks without involving people. Some people were more independent and were able to do more for themselves. Staff did not actively encourage people to get involved.

At the last inspection people were unable to leave the service without seeking permission from staff to unlock the front door. At this inspection some improvements had been made. People who were able to go out independently were able to use a side door with a key pad lock to come and go as they pleased. Staff said that people now accessed the main kitchen more and that they could use the small kitchen whenever

they wanted to make drinks or snacks. The first day of the inspection was very hot. Cold drinks were not readily available for people so they could help themselves. People had to request drinks from staff from the main kitchen. When we asked staff why they did they not leave jugs of drinks for people so they could help themselves, they did not know why. On the second day of the inspection the small kitchen door was locked so people had to ask staff permission to open the door. When we pointed this out to staff they said the door should have been left open.

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

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

There was personalised information about people's background and life events. Staff had knowledge about people's life history so they could talk to them about it and were aware of any significant events. People who were important to people like members of their family and friends were named in their care plan. This included their contact details and people were supported to keep in touch. People went to visit their families and spend time with them and relatives and friends could visit people at the service at any time.

Staff asked permission before intervening or assisting. There were friendly conversations between people and staff. Those who could not fully express their needs received the right level of support, for example, in managing their food and drink. People told us they chose what food they wanted, when they got up and went to bed.

Staff told us that some people liked to go to church on occasions and that they supported them with this. Records of a recent residents meeting noted, '[One person] stated they would like to go to the church. [Staff member] will arrange for this Sunday'. The person told us they were supported by staff to go to church when they chose to.

People's care plans and associated risk assessments were stored securely and locked away so that information was kept confidentially. People who needed support to air their views were supported by their families or their care manager. People who needed support to make decisions about their care could be supported by the local advocacy service. An advocate is an independent person who can help people express their needs and wishes, weigh up and take decisions about options available to the person. They represent people's interests either by supporting people or by speaking on their behalf.

Inadequate

Is the service responsive?

Our findings

Visiting professionals said, "It's not a positive environment here. There are lots of restrictions. People were not given the chance to do things for themselves". "Staff are not proactive they are reactive. They do not understand that some people need routines and consistent approaches.
"Staff are not able to manage some people's behaviour".

A professional told us they had met with one person who liked to dress in a certain way and have their hair and make-up done. The professional told us that the person had not been supported to do this. The person had not been to the hairdresser since January 2017. They said that the person looked unkempt.

Due to the level of concerns the local safeguarding team were undertaking investigations into some allegations. Everyone living at Phoenix House was being reviewed by social workers and care managers to make sure they were safe and receiving the care and support that they needed.

No new people had moved into the service since our last inspection. People's care plans were in the process of being reviewed and updated but people were not involved with this. The guidance and information in people's care plans varied. Some care plans contained detailed information about how to care and support people and others did not. One plan stated, 'Staff and keyworker to support [the person] when agitated'. There was no information about what support was needed.

When people displayed behaviour that could be challenging incidents were not consistently and clearly documented. There was limited detail about what triggers might lead to a person becoming distressed. There was no information about the early signs to look for or what action the staff needed to take to support the person in a way that suited them best.

Some people had mental health needs and learning disability needs. There was no information in their care plan about their learning disability needs and how best to support people with certain learning disability conditions. A visiting professional said the staff were not able to meet the persons' needs and they were looking for a new placement.

Staff people and visiting professionals said that there was a lack of meaningful activities for people.

Visiting professionals said that they felt there had been an increase in incidents as people were bored. One professional told they had had set up an art activity for one person as part of an assessment. They said when they did this other people came into the room and wanted to join in. They said people were keen and interested to do something.

On the days of the inspection there were no activities taking place for people. Staff were busy undertaking tasks and did stop and chat with people as they went by.

The main activity that most people took part in was smoking. People had a cigarette every hour. People had

agreed to this as they wanted to make their cigarettes last. Everyone went outside to the smoking area together to smoke every hour. People seemed to be just waiting for the hour to be up so they could have their next cigarette. There was no other distraction or activity on offer for people to take part in.

On the days of the inspection we observed people wandering around. Staff did not attempt to engage them in any activities.

Records of a recent staff meeting noted, '[Staff member] expressed that residents want to go out more now that the weather is better'. A member of staff told us, "We [staff] have been saying for months that there is not enough for people to do. We have suggested group activities like going to the cinema or the zoo but there isn't any funding".

People confirmed that when there were activities, they were supported and encouraged to take part in them. Some people could go out on their own and came and went as they pleased. Other people needed support when they went out. People said they enjoyed activities outside the service and sometimes shopping trips and visits to local places of interest were arranged. There were some links within the local community but these were not maximised. People sometimes went to the local pub for a drink or to the nearest town to do shopping or have a meal. People were supported to attend churches if they wished to do so.

The provider had failed to involve people and their relatives 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.

People told us they knew how to complain. They said they would speak with staff and knew they would be listened to and that their concerns would be acted on. A system to receive, record and investigate complaints was in place so it was easy to track complaints and resolutions. The complaints procedure was available to people and written in a format that people could understand. When an external complaint was received this was recorded and responded to. Records showed the action that was taken to address the issue. However, not all concerns and complaints made by people and staff were dealt with appropriately. Staff told us that they had complained about an issue but the appropriate action was not taken. People said they complained about lack of activities but nothing had changed.

The provider had failed to take appropriate action for managing complaints. This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The previous inspection of this service was carried out on 13 December 2016 when we found breaches of the regulations. The service was rated 'Requires Improvement' and 'Inadequate' in the 'well-led' domain. The provider sent an action plan to CQC in February 2017 with timescales stating they would be compliant with the regulations by March 2017. At this inspection the provider had failed to comply with their action plan and there were continued breaches of the regulations relating to safe care and treatment, treating people with dignity and respect that promoted their independence and autonomy, person centred care and good governance. There were also new breaches identified relating to need for consent, safeguarding people from abuse and proper treatment, staffing, and not notifying the relevant bodies when incidents occurred at the service.

The registered manager was no longer working at the service. The provider had employed a new manager but they only stayed for two months. Another manager had since been appointed and they started working on 10 July 2017.

We returned to the service on the 11 July 2017 and met with the provider and the new manager. We explained that we had serious concerns about people's safety and about the high levels of risk. People were at risk of not receiving the care, treatment and support that they needed in the safest way. We gave examples of the shortfalls identified. The provider and new manager agreed they were 'worrying' and 'serious concerns'. The provider told us that the lack of consistent management had led to the deterioration of the service. The business manager and deputy manager from the providers other service were spending time at Phoenix House to support the people and staff. We requested an urgent action plan from the provider. The action plan did not cover all of the issues and risks so we requested a further action plan.

People, staff and visiting professionals told us that the service was not well led and not well organised. People said, "It used to be much better here. We did more, I had a key worker. It has all changed". There was a lack of leadership and direction and there was a lack of oversight, scrutiny and governance. There was a lack of transparency and openness. When staff had raised concerns with the management the appropriate action had not been taken. Staff said that when they had raised concerns to management about people's safety the appropriate and necessary action had not been taken and people had been left at risk. The management had not identified and raised incidents with outside agencies as they are required to do.

The service's visions and values were to support and care for people and to keep them safe and to offer rehabilitation to the people it supports. This had not happened. People were not protected and kept as safe as possible and there were limited opportunities for people to learn new skills or maintain skills they had previously developed.

There was a culture of containment at times where staff watched over people and a focus on reacting to people rather than supporting them to live a meaningful life. There was little emphasis on developing people's day to day skills, independence and understanding. Staff did for some people rather than with them. The provider had not taken action to change the culture.

Records were not always detailed to ensure that staff had the guidance to provide safe care, such as recording information in the risk assessments to ensure that staff had clear guidance of how to mitigate potential risks such as managing people's behaviour effectively and safely.

Audits had not been carried out recently on care plans and risk assessments to make sure they contained the correct information and guidance for staff so people received safe personalised care and support. Some care plans and risk assessments had been reviewed and updated but were lacking in detail so people were still at risk of not receiving the safe personalised care and support. This had not been identified as an issue as they had not been looked at by the provider.

Checks on the environment, such as water temperatures, portable appliance tests and legionella tests were regularly completed. Team leaders had recently been given responsibility for completing a number of audits, such as medicines and infection control. However, these checks had not yet been implemented.

When shortfalls had been identified action had not been taken consistently. For example, an environmental risk assessment detailed what actions were needed. There were no timelines to prioritise when work needed to be completed.

Staff meetings were held regularly with the management team to discuss any issues and how improvements could be made. Changes to the how staff were working, staff supervisions and activities for people had been discussed. Actions had been identified but they had not been implemented. For example, staff were to have regular supervisions starting in April 2017. This had not happened.

Since the last inspection there had been a lack of improvements and development of the service. The quality of the care had declined and there were continued breaches of regulations.

The provider sought feedback from people, their relatives, professionals and staff through surveys. The most recent survey had been completed in November 2016 before the registered manager had left. The feedback was generally positive. However views from people and staff about the lack of activities had not been acted on.
The provider had failed to identify the shortfalls at the service through regular effective auditing. The service had not improved or developed. This was a continuous breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. CQC check that appropriate action had been taken. Notifications had not been submitted in line with guidance. For example there had been a number of reportable incidents where people had been hurt which had not been reported to CQC or to the local safeguarding authority.

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

Providers are required, by law, to display their CQC rating to inform the public on how they are performing. The last CQC rating was not displayed at the service and was not displayed on the provider's web-site. These shortfalls were addressed immediately.

Relatives had commented 'Staff support [my loved one] in every way, anticipating all of their needs' 'I have complete confidence in all the staff. They treat [my loved one] with loving care [My loved one] is very happy

there which is all I could ask for'. 'Excellent contact with friends and family. I have much trust in the staff. They contact me when and if required'.