Phoenix Residential Care Homes Limited

Phoenix Residential Care Home

Inspection report

45 Maidstone Road
Chatham
Kent
ME46DP
Tel: 01634 841002

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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**

Overall summary

The inspection was carried out on 16 and 18 November 2015 and was unannounced.

The service provided accommodation and personal care for up to 18 older people some of whom were living with dementia. The accommodation is arranged over two floors. There is a lift to assist people to move between floors. There were 14 people living in the service when we inspected.

The service did not have a registered manager. The previous registered manager had ceased working at the service in August 2015. There was an acting manager in place who advised us they were planning on applying to become the registered manager.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During this inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not safeguarded against abuse or the risk of abuse. There were not enough staff to keep people safe and meet their needs. Staff were not adequately trained to meet people's needs. People were not adequately protected from the risk of malnutrition and dehydration. People did not receive personalised care. People's dignity was not always protected. People were not provided with activities which met their needs. Complaints were not dealt with in a timely manner. Quality assurance systems were not effective. Records were not accurate or maintained.

Some people made complimentary comments about the service they received. People told us they did feel safe and well looked after. However, our own observations and the records we looked at did not always match the positive descriptions people had given us. Some of the relatives we spoke with were happy with the service being provided and others we spoke with had raised concerns with the manager which they felt had not been dealt with. We had received a number of concerns from various sources prior to the inspection. These concerns were regarding lows levels of staffing, poor quality of food and small portions, lack of activities, staff training and a lack of healthcare products such as incontinence aids for people. These concerns were substantiated from our observation during our inspection.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. At the time of the inspection, the previous manager had applied for DoLS authorisations for some people living at the service. Staff however did not understand their responsibilities the procedures of the Deprivation of Liberty Safeguards and where unaware that some people had applications to have their liberty deprived. Procedures had not been followed in relation to the Mental Capacity Act 2005. People had not been supported to complete a mental capacity assessment before decisions were made on their behalf. A mental capacity assessment determines if a person has the capacity to make specific decisions about their lives.

Not all staff had received the essential training or updates required to meet people's needs. This included training in the Mental Capacity Act 2005 (MCA) and preventing and managing behaviours that were a risk to the person or others.

People were not protected from the risk of abuse. Staff had not received training or guidance relating to the protection of vulnerable adults. Staff were unclear of the actions they should take if they identified or suspected abuse.

The provider did not have an effective system to check how many staff were required to meet people's needs and to arrange for enough staff to be on duty at all times. Staff told us and we observed that there were not enough staff to meet people's needs.

Safe recruitment procedures had not been followed to make sure staff were suitable to work with people. Two people had started working at the service before a Disclose and Baring Service (DBS) background check had been obtained. These checks ensure people were safe to work with vulnerable people.

People or their relatives were not involved in developing a care plan to meet their needs. People's needs were not always assessed to ensure staff knew how to meet people's needs. Potential risks to people's safety and wellbeing had not been assessed or recorded.

People's weights were not being monitored accurately to make sure they were getting the right amount to eat and drink, there was a risk of people experiencing malnutrition. There were mixed views about the meals, some people were complimentary but other people were surprised at the small amount of food they had been given. Advice from health care professionals had not always been sought in a prompt manner when people showed signs of illness.

Information regarding complaints was not easily accessible to people or their relatives. Complaints that

Summary of findings

had been raised had not been recorded. There was no system to make sure prompt action was taken and lessons were learned to improve the service being provided.

Quality assurance systems had not been effective in recognising shortfalls in the service. Improvements had not been made in response to accidents and incidents to ensure people's safety and welfare. Records relating to people's care and the management of the service were not well organised or adequately maintained.

People some of whom were living with dementia were not provided with meaningful activity programmes to promote their wellbeing. People were supported to maintain their relationships with people that mattered to them. Visitors were welcomed at the service at any reasonable time.

People received their medicines safely as prescribed by their GP.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

You can see what action we told the provider to take at the back of the full versions of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

People were not protected from abuse or the risk of abuse.

There were not enough staff on duty to meet people's needs.

Risks to people's safety and welfare were not identified or managed to make sure they were protected from harm.

People received their medicines as prescribed by their GP.

Inadequate

Is the service effective?
The service was not effective.

Staff did not have the knowledge and skills to make sure people were getting enough to eat and drink.

Staff did not understand the requirements of the Deprivation of Liberty Safeguards. There were no clear procedures in place in relation to the Mental Capacity Act 2005.

Staff did not have all the essential training or updates required to meet people's needs. Staff did not receive the supervision and support they needed to carry out their roles effectively.

People were not supported effectively with their health care needs.

Inadequate

Is the service caring?
The service was not caring.

Staff were not always kind, caring and patient when talking and supporting people with their needs.

People were not always consulted about their own care.

People's dignity was not consistently considered.

Inadequate

Is the service responsive?
The service was not responsive.

People living at the service were not supported to take part in meaningful, personalised activities.

People had not had their needs properly assessed before moving in and when they did move in their needs were not met. People's care had not been planned or updated when there were changes in their needs.

Complaints were not managed effectively to make sure they were responded to appropriately.

People were able to have visitors when they wanted to.

Inadequate

Summary of findings

Is the service well-led?	
The service was not well-led. Quality assurance systems were not effective in recognising shortfalls in the service. Action had not been taken, to make sure people received a quality service. Records relating to people's care and the management of the service were not well organised or adequately maintained. Accidents and incidents had not been analysed or any action taken. Staff felt there was an open culture within the service.	**Inadequate**

Phoenix Residential Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 16 & 18 November 2015 and was unannounced.

The inspection team included four inspectors, an inspection manager and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We gathered and reviewed information about the service before the inspection including information we had received from relatives, staff and the local authority about the service.

We would normally ask the provider to complete a Provider Information Return (PIR). This is a form that asks for some key information about the service, what the service does well and improvements they plan to make. However, this inspection was planned in response to concerns we had received and there was not time to expect the provider to complete this information and return it to us. We gathered the key information during the inspection process.

We spoke with ten people about their experience of the service and four relatives of people using the service. We spoke with five staff including two care workers, two team leaders, an apprentice and the manager to gain their views.

We spent time looking at records, policies and procedures, complaint and incident and accident monitoring systems. We looked at five people's care files, five staff record files, the staff training programme, the staff rota and medicine records.

This was the first inspection of the service since it was registered with the Care Quality Commission.

Inadequate

Is the service safe?

Our findings

People told us they felt safe most of the time. However, more recently people said they had not felt safe. They said “I have had to lock my bedroom door at night because another resident came into my room and woke me up.” Another person told us that another resident had entered their bedroom and claimed they were their loved one, which had frightened them.

Staff we spoke with were not clear about how they could report any concerns they had outside of the organisation. All staff said that they would report any concerns to the manager of the service. One member of staff told us they would not raise any concerns they had outside of the service, with another member of staff saying if the manager was not around they would contact social services. Staff we spoke with were not sure if they had received any training regarding safeguarding vulnerable adults from potential harm and abuse. One member of staff told us that they had completed training at their previous employment but they had not completed any other training since starting work at the service seven months ago. The staff records we looked at did not show that staff had received training in how to safeguard people. The manager told us they were in the process of sourcing an e-learning system to use. Training had been arranged for staff by the provider on how to safeguard people and the Mental Capacity Act on the 18 November 2015, but the provider had cancelled the training. There was a Safeguarding of Vulnerable Adults from Abuse policy within the service which staff did have access to but had not used it. This policy was issued in September 2014 and was due for review in September 2015, no review had taken place so there was a risk the policy did not contain up to date information. The policy had not been reviewed prior to the opening of the service. The policy contained the contact numbers for the local authority safeguarding team.

People were not protected from abuse and improper treatment. This was a breach of Regulation 13 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not enough staff on duty at all times to make sure that people were protected from harm or received the individual care they needed. One person told us that they were left using the bathroom for a long period of time “Because there was not any staff to help me.” The number of staff employed was not based on an analysis of how much time was needed to provide appropriate levels of care and activities for people. The manager and staff told us there were not enough staff to meet people’s needs. Some people living at the service required the support of two staff with certain tasks such as using the bathroom. One member of staff said “I have to wait for the other member of staff to finish what they are doing before they can come and help me, I just have to tell the person to wait.”

There were two members of care staff on duty at the time of the inspection with an apprentice who was not able to complete personal care tasks. Staffing levels remained consistent with two care staff being on duty for the previous eight weeks of rotas we saw. The staffing levels had not increased or decreased as a result of new admissions to the service. Relatives told us they felt there were not enough staff on duty.

Our observations showed there were not enough staff with the appropriate qualifications, skills and experience to provide appropriate care which ensured people’s safety and wellbeing. There were periods of time of up to ten minutes in the main lounge and up to fifteen minutes in the blue lounge without any staff present. One member of staff told us “We just do not have enough staff, with the additional tasks such as cleaning and the laundry.”

Some people were behaving in a way which placed themselves or others at risk of harm. We observed one person take away another person’s walking aid as they were walking to their bedroom. The person had to support themselves on a nearby table because they did not have their walking aid and called for help from the staff. On another occasion we observed a person leaning over another resident who was seated in a chair. This person appeared very distressed and was continually asking the gentleman to move away from her. We intervened and found staff to support the person. Staff were not available to support people at either incident because they were elsewhere in the building. Staff arrived when people called for help, however, staff did not respond appropriately to either incident because they had not been trained to understand how to protect or care for people with dementia. The response by staff on both occasions was to move the person out of the way, staff did not explain what they were doing or offer any alternative activity or reassurance.

Inadequate

Is the service safe?

Staff were responsible for completing cleaning and laundry tasks as well as meeting people's needs. The lounge had an unpleasant odour which continued into some of the bedrooms. We observed a stain of what appeared to be faeces on a person's bedroom carpet on the first day of our inspection, the stain was still there on the second day of our inspection. The laundry room had an unpleasant odour of soiled laundry and stagnant water. The manager informed us the washing machine has broken which meant staff were taking non soiled washing home with them to wash. In the corner of the room there was a drain which was filled with dirty brown water. The manager told us the pump had broken which is why the water had not drained away. The washing machine continued to be out of action on the second day of our inspection.

There was not enough staff to meet people's needs safely at all times. This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment files kept at the service did not contain the information required under schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Of the five files we checked one person had no proof of identity. Two had had only one reference with another stating the reference was not acceptable and four had no proof of qualifications. We could not be satisfied that staff had references and checks completed before starting work due to the lack of records available. Two people had started working at the service before a Disclose and Baring Service (DBS) background check had been obtained. These checks help to ensure people were safe to work at the service.

Recruitment information was not available in relation to each person employed. The examples above were a breach of Regulation 19 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Potential risks to people in their everyday lives had not always been assessed or recorded. Three of the five files we viewed did not contain any information about managing any risks to people even those these people were exposed to potential risks of harm. The two other files contained risk assessment relating to falls. These assessments had been carried out in August 2015 and highlighted that these people were at very high risk of falls. Accident and incident records showed that there had been a high number of recurrent unwitnessed falls for these two people. One person had six falls recorded since June 2015, records had not been reviewed as a result of these falls. No action had been taken in response to people's changing needs.

Risks relating to people had not been assessed or acted upon. This was a breach of Regulation 12(2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safety checks were carried out at regular intervals on all equipment and installations. Although there were systems in place to make sure people were protected in the event of a fire, the weekly fire alarm test had not been completed since 25 March 2015. These checks form part of the safety monitoring. There was equipment in place in case of a fire such as fire extinguishers. Fire exists were clearly marked and accessible. A fire risk assessment of the premises had not been carried out by a suitably qualified person.

We recommend that the provider seeks advice from a suitably qualified person to ensure any risks of fire are identified and minimised.

Medicines were managed safely. People told us they received their medicines regularly. All medicines were stored securely and appropriate arrangements were in place for ordering, recording, administering and disposing of prescribed medicines. Clear records were kept of all medicine that had been administered. The records were up to date and had no gaps showing all medicines had been signed for. Any unwanted medicines were disposed of safely. Clear guidance was in place for people who took medicines prescribed 'as and when required' (PRN). There was a written criteria for each person, in their care plan and within the medicine files, who needed 'when required' medicines. This gave people assurance that their medicine would be given when it was needed. Medicine audits were carried out and recorded by team leaders on a monthly basis.

Inadequate

Is the service effective?

Our findings

People we spoke with told us the food was very nice. One person said "At breakfast we can have eggs on toast if we want it." The menus had recently been changed to include a choice if hot meal at lunch and tea time. People were offered a choice of meals for lunch and tea which included chicken curry, macaroni cheese, jacket potatoes and sandwiches on the day of the inspection. At tea time some people had chosen a jacket potato with cheese, when this arrived we heard two people asking if this was all they were going to get to eat. The staff responded by saying that was what they had chosen for their tea. On the second day of the inspection we observed a person for something different to what they had been served for lunch, this was accommodated by the staff.

The staff files we looked at showed people had no training in how to provide people with adequate nutrition. Staff were not monitoring people's weight effectively to identify any risks of malnutrition and to ensure prompt action was taken. We looked at three files of people who had lost weight since moving into the service, one of the files contained a weight monitoring form with an action plan for staff to record foods eaten. The other two files had identified people had lost weight but no action had been taken by the staff. We spoke to the chef about people who had any dietary requirements. The chef told us that there were three people who had diabetes, and, as a result any puddings they made did not contain sugar and were suitable for people with diabetes.

People told us that they did not feel able to access drinks or snacks outside of mealtimes. One person said "If we are at the hairdressers or doing something else we miss our tea and coffee, the staff say we then have to wait until mealtime." Jugs of water and squash were available in the lounge if people were able to get up and help themselves. People were not offered these drinks and we did not observe anyone pour a drink for themselves. A relative told us that they had informed the staff about ensuring drinks were offered to their family member but this had not happened. We observed a person ask a member of staff for a cup of tea before lunch, the staff informed them they would have to wait until after lunch.

People were not provided with the support they needed to eat and drink the right amounts to protect them from the risks of inadequate nutrition and dehydration. This was a breach of Regulation 14 (1) (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Staff were not always aware of their responsibilities under the Mental Capacity Act (MCA) 2005, and the Deprivation of Liberty Safeguards (DoLS). Staff had not received training to understand and use these in practice and did not completely understand how DoLS affected the people living at the service. Staff told us they were unsure if anyone at the service had a DoLS authorisation in place, when in fact some people living at the service had DoLS applications which were completed by the previous manager for restrictions in place. We found that there were restrictions imposed on people where their best interests had not been considered. People were not able to leave the premises as all external doors were locked some with the use of a key pad. People could have been deprived of their liberty without the staff being aware they had been. For example, people were not able to access all areas of their home.

There were no clear procedures in place or guidance in relation to the Mental Capacity Act 2005 (MCA) which included steps that staff should take to comply with legal requirements. The provider had not properly trained and prepared their staff in understanding the requirements of the Mental Capacity Act 2005, and the specific requirements of the Deprivation of Liberty Safeguards (DoLS). Training in MCA had been arranged for the 18 November 2015 but this was cancelled by the provider. The staff were unable to describe their responsibilities in supporting people to make decisions or in seeking advice when people were unable to do so. We saw a record within a person's care file which was written by a family member stating that they had given permission for another person to make decisions on behalf of their loved ones. The person had not been supported through a mental capacity assessment which determines if a person has the capacity to make specific decisions about their lives.

Inadequate

Is the service effective?

The provider did not have suitable arrangements in place for obtaining and action in accordance with people's consent. This and the examples above were a breach of Regulation 13 (2) (4) (a) (b) (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had not received the support and training they required to fulfil their role. There was not a process in place to monitor the staff training that was required to meet people needs. Some of the staff we spoke with told us they had not received any training since joining the service. Records we looked at confirmed that some staff had not completed training specific to their role, including, infection control, safeguarding adults and the Mental Capacity Act 2005. Staff had not received any training to meet people specific needs such as diabetes, incontinence and challenging behaviour. The manager told us they were in the process of sourcing an online training provider. Two staff told us they had not received an adequate induction when they started working at the service. All of the staff files we looked at contained induction checklists which had been completed by a member of the management team. The induction did not include any time working alongside permanent staff to get to know the people living at the service.

Staff had not received supervision with their line manager. These meetings provided opportunities for staff to discuss their performance, development and training needs. Of the five staff files we viewed, only one had a record of a CPD (Continuous professional development) form to demonstrate that supervision with the manager had occurred. The record showed that actions were set, however, as the CPD was carried out two weeks prior to the inspection it was not evident whether the actions had been completed or not. The staff continuous professional development procedure stated "The frequency of SCPD will vary according to the nature of the position held and maybe subject to mutual agreement between an employee and their line manager. However for front line operations employees SCPD must take place at lease every two months." Staff had not received supervision in line with the provider's procedure.

Staff had not received appropriate training, support and supervision to carry out their role. This was a breach of Regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they had access to health care professionals when they needed one. One person told us "If we are unwell, they (the staff) call the doctor to come." Another person said they saw the district nurse on a regular basis. The records we looked at were not clear if people were accessing the health care they required. Of the four care files we looked at, one contained information relating to visits from the chiropodist and opticians. Records showed that prompt action had not been taken by staff for recurrent health concerns. We saw that there had been eight admissions to hospital with eight prescriptions of antibiotics for a recurrent health problem. Although staff had monitored and recorded the occurrences they had not made a prompt referral for medical attention or advice. The person told us they felt embarrassed by this. People had not been supported to remain as healthy as possible.

People were not supported to have a plan and deliver care that protected people's safety and welfare. This was a breach of Regulation 9 (1) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

Most people told us that the staff were kind and caring. People said the staff treated them with dignity and respect. However, comments from some people and our observations did not always match the positive descriptions people had given us. We observed two instances when staff were not respectful when talking to people. One person was distressed that they were not able to get their hair washed and blow dried on the first day of the inspection. A member of staff shouted across the lounge to the person and said "Your name was not down on the list today." This appeared to cause the person further distress as they started to cry and said to the staff that they have their hair done every week. The other occasion we observed was during lunch when a person was not comfortable on the chair they were sitting on. Staff tried to encourage the person to move onto another chair but they were not able to. When the person was trying to move to the other chair a member of staff said "Are you being lazy today." And "If you are not comfy I am not going to feed you." This was said in front of other people who were having their lunch and did not show that the staff had considered the person's dignity.

Some relatives made positive comments about the care. They said, "The staff are very friendly and welcoming." Other relatives had made complaints to the manager about issues within the service and told us they were not satisfied. One relative told us they were concerned about the lack of care staff on duty, the cleanliness of the service and that their family member often wears the same dirty clothes. A comment was made on the second day of the inspection that the staffing numbers had improved. After the first day of the inspection we spoke with the provider and discussed our concerns around the levels of staff on duty, as a result the provider had increased the staff on duty to three from the second day of the inspection.

On the second day of the inspection we saw a person talking to the manager about how they wanted to receive care and support. The manager recorded the discussion to develop a care plan. This meeting took place in the lounge where other people were present. Personal and confidential information had been discussed in the presence of other people living at the service.

People were not always treated with dignity and respect. This was a breach of Regulation 10(1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People or their relatives had not been involved in planning their care. Relatives told us that the staff had not had time to sit down with them and develop a care plan. People's care plans did not contain information about their preferences, likes, dislikes and interests. Some relatives had written about their family member's life history to help staff get to know about peoples' backgrounds. Staff we spoke with said they knew some people's life histories but not everyone. We asked a member of staff what they could tell us about a person living at the service; the staff replied "They have severe dementia and challenging behaviour." This person had a detailed "This is me" information sheet which had been completed by their relative. The member of staff did not list anything which had been documented about this person.

People or their representatives were not involved with the planning of their care. This was a breach of Regulation 9 (1) (3) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service held a residents meeting to enable people to share their views about the service. A meeting which was held on the 5 November was attended by 11 people and also some relatives were present. People were asked about the food and whether there was anything they would like to add to the menu, some requests included cheese on toast and bacon sandwiches. We were unable to see from the records if these requests had been accommodated.

Inadequate

Is the service responsive?

Our findings

People were encouraged to help around the service by laying the table for meals, washing up and folding laundry. One person told us "I enjoy doing jobs around the house, it gives me a sense of purpose." However we saw that people completed tasks which the staff did not have time to complete. We observed one person carrying dinner lap trays from one room to another and being thanked by a member of staff for doing this. This person had been assessed as not being able to carry objects due to the risk to themselves and others.

An activity timetable was displayed on the notice board which included social activities such as quizzes, nail painting and bingo. A music and gentle exercise session was taking place on the first day of our inspection, this took place on a monthly basis and received positive comments. On the second day of our inspection bingo was due to take place in the morning. Staff informed people that they were going to play bingo and instructed people into the lounge. People came into the lounge to start the session, when a member of staff whilst speaking to the other member of staff said not to play the bingo until later on. People were left in the lounge expecting to play bingo but this did not take place, people appeared disappointed about this. One relative commented that they were very surprised and pleased that their loved one wanted to participate in the bingo. People's interests had not been taken into account when planning activities.

One person told us "I wish I could go out sometimes, but I cannot go out on my own and there is no one to take me." Planned activities took place within the service and did not provide an opportunity for people to access the community. Some people were taken out into the community by their relatives but this did depend if people had family who were able to accommodate this.

People who were supported by staff to sit in the lounge were not offered anything to look at or interact with such as magazines, books or objects that might interest them. The manager told us that the service had a selection of book in the loft area and that a person was interested in horror books. This person had not been given any horror books to read as the staff had told the manager "It would play with the persons mind."

People moved into the service without a full assessment of their needs, behaviours or the resources available to manage their care. Pre-admission assessments had been completed with basic details about people's medical histories and needs. However, following the basic assessment due consideration had not been given to the level of support, the number of staff or the training they needed. A number of people had complex needs which staff were not trained or supported to respond to.

Pre admission assessments did not take account of the needs of people already living at the service or how behaviours would affect them. A decision was made to move a person into the service without consideration of the effect on the person moving in, or the people already living in the service. The manager told us they had recognised this was having a negative impact on the new person's and other people living at the service wellbeing. A transition plan had not been put in place to ensure the person was fully supported and the service was able to meet their needs.

Three of the five files we viewed had a care plan which contained limited information about how people wanted their care delivered. Two of the files we viewed did not contain any information relating to how people wanted to be supported. One person had recently moved into the service four days prior to the inspection the other person moved in two months prior to the inspection. Staff had limited guidance about how to provide care and support in a personalised way. Information supplied by relatives in the "This is me" document, had not been used by the staff to give personalised care or to plan meaningful activities for people.

People's preferred routines were not included in their care plans, such as what time they wanted to get up or go to bed or when they would like a bath or shower. When asked about baths or showers people told us they could have a bath or shower when they wanted one; however, records we saw showed that over a seven day period only one person had been supported to have a bath. On average five people per day were supported by staff to have a wash. One person told us that if they had a choice they would have a bath every day.

Inadequate

Is the service responsive?

The examples above mean the provider had failed to plan and deliver care which met people's individual needs or ensured their welfare. This was a breach of Regulation 9 (1) (a) (b) (c) (2) (3) (a) (b) and (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a complaints policy and procedure in place, however this made reference to the previous registered manager who had left the serviced three months prior to the inspection. Staff told us there was a "Comments and suggestions" book in place, although they were unsure about how complaints were dealt with. We looked at the comments and suggestions book which had been out into place, the book was empty. A relative told us they had made complaints to the manager which had not been dealt with effectively.

The provider did not have an effective system in place for managing complaints. This was a breach of Regulation 16 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People could have visitors when they wanted to and there were no restrictions on what times visitors could call. People were supported to have as much contact with their friends and family as they wanted to. Relatives told us they were kept informed about their relative and were welcomed when they visited. People had numerous visitors during our inspection. One relative told us they came to visit their family member nearly every day. Another said "We can speak to the manager if we wish and sometimes the owner."

Inadequate

Is the service well-led?

Our findings

There was a manager at the service who had been made the temporary manager from their team leader position since the previous manager left. The manager was supported by three team leaders who managed the care staff. Staff understood the management structure of the service, who they were accountable to, and their role and responsibility in providing care for people. The manager told us they were supported by the provider who visited the service on a weekly basis. The manager knew each person by name and people knew them and appeared comfortable with them.

People and the relatives we spoke with knew who the manager was and said they were able to speak to the manager if they wanted to.

Phoenix Residential Care Home had a 'Service user guide' which was on display near to the front door. This stated, 'Aims and objectives of the home' were too 'Provide all residents with a quality of care that will enable them to live as independently as is possible with dignity, privacy and the opportunity to make their own choices' and 'To carry out individual assessments of the resident's needs that will be used to develop individual care plans.' Our finding during the inspection showed that these aims and objectives were not being communicated clearly to the staff or put into practice.

There was no system to assess how many staff with the right skills were required at all times to provide people with safe, effective, caring and responsive care. Staff and relatives told us there were not enough staff to meet people's needs. There was no system to make sure staff received the support and supervision they required to allow them to discuss their role, their training needs and their work standards.

The provider did not have an effective system in place to regularly assess and monitor the quality of the service provided. An external audit of the service was completed in June 2015, this highlighted that the staff were 'very stretched' and at the time were having to cook dinner in addition to care tasks. As a result of that audit a chef was employed to manage the kitchen. Audit schedules were in place but they had not been completed, for example, water temperature monthly checks were last completed 15 April 2015 and the monthly health and safety audit had not been completed as the section was empty. These checks were designed to minimise the risks to people's safety that use the service. A daily health and safety walkthrough was in place which included, any odour issues, any fire doors propped open, kitchen check and were the staff working safely. This had last been completed by the manager on the 23 October 2015. Accidents and incidents had not been analysed to find any patterns or trends, this information could be used to reduce the risk of reoccurrence. Due to the lack of checks and audits in place the manager had not identified what we had observed during the inspection.

Records relating to people's care and treatment were not well organised or adequately maintained. A number of records we looked at were not accurate or kept up to date, including care plans, records of people's weight and potential risks either to themselves or others. This meant that staff and others did not have consistent information and people were not receiving planned care that met their needs.

The provider did not have effective systems in place to asses, monitor and improve the quality of the service being provided to people. This was a breach of Regulation 17 (1) (2) (a) (b) and (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had recently held a residents meeting based on feedback from the staff team regarding the food. It was unclear whether these meetings were going to take place on a regular basis. A survey requesting feedback about the service had recently been sent out to relatives. At the time of our inspection the feedback had not been looked at and feed back to the people living at the service.

The provider had a wide range of policies and procedures which were available to staff, however these made reference to the previous manager and were overdue for review. The procedure for taking action when a member of staff was not fulfilling their role had not been followed. Records we saw did not follow the disciplinary procedure which was in place.

Staff felt there was an open culture within the service and they were able to express their views. The manager told us that they felt staff did not always come directly to them with their views. Relative's told us they knew who the

Inadequate

Is the service well-led?

manager was and felt they were able to speak to them if they needed to. The manager told us they planned to become registered with the Care Quality Commission and become the registered manager of the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Regulation 19 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Recruitment information was not available in relation to each person employed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12(2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Risks relating to people had not been assessed or acted upon.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs Regulation 14 (1) (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not provided with the support they needed to eat and drink the right amounts to protect them from the risks of inadequate nutrition and dehydration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

This section is primarily information for the provider

Action we have told the provider to take

Regulation 10(1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints Regulation 16 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: The provider did not have an effective system in place for managing complaints.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 (1) (2) (3) (4) (a) (b) (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have suitable arrangements in place for obtaining and action in accordance with people's consent.

The enforcement action we took:
Warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff had not received appropriate training, support and supervision to carry out their role.

The enforcement action we took:
Warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 (1) (a) (b) (c) (3) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not supported to have a plan and deliver care that protected people's safety and welfare. People or their representatives were not involved with the planning of their care.

This section is primarily information for the provider

Enforcement actions

	The provider had failed to plan and deliver care which met people's individual needs or ensured their welfare.

The enforcement action we took:
Warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (1) (2) (a) (b) and (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: The provider did not have effective systems in place to asses, monitor and improve the quality of the service being provided to people.

The enforcement action we took:
Warning notice.