Phoenix Residential Care Homes Limited

Phoenix Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 27 and 28 November 2018. The inspection was unannounced.

Phoenix Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Phoenix Residential Care Home provides accommodation and support for up to 18 older people. There were 17 people living at the service at the time of our inspection. People had varying care needs. Some people were living with dementia and some had diabetes or were recovering from a stroke. Some people required support with their mobility around the home and others were able to walk around independently.

The registered manager was also the provider. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection on 10 October 2017, the service was rated as 'Requires improvement. We found breaches of Regulations 9, 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to, the care planning and review system did not meet people's needs and preferences; people's medicines were not managed safely; monitoring systems did not identify shortfalls in quality and safety.

The registered manager sent us an action plan following the inspection, on 22 January 2018, detailing what they planned to do to make improvements, although the action plan did not confirm a date when they expected to be compliant by. At this inspection, the registered manager had followed their action plan and made improvements in some areas; people's needs and preferences were identified through the care planning process. However, other parts of their action plan had not been completed as promised as, the management of people's medicines needed to improve as they were still not safe; the monitoring of quality and safety continued to be ineffective and the management and leadership was in question as the service had failed to improve. We also found many other areas of concern.

Assessments had not always been carried out to identify risks to people's safety and to put individual measures in place to protect them from harm. People whose behaviours challenged others were not always supported using a positive approach. Incidents of challenging behaviour were not recorded appropriately and not monitored to provide better outcomes for people. Safe infection control procedures were not always followed.

A strong odour was present during this inspection and the last inspection and had also been raised as a concern by relatives and others at various times. This had not been rectified.

Mental capacity assessments had not been carried out where a person's capacity to make some decisions was in doubt. DoLS authorisations had been applied for and were either in progress or had been authorised by the local authority.

People had been referred to healthcare professionals when required. However, the advice given had not always been recorded within people's care plans to make sure the advised treatment was followed correctly, such as their skin care and nutrition and hydration, which compromised their safety.

Staff had basic mandatory training but had not received specific training to make sure they had the knowledge and skills to meet people's individual needs and tasks that were requested of them. Evidence was not available to show that the staff who delivered training had the necessary qualifications to do so.

People's records had not always been accurately maintained to provide an up to date account of people's care needs. End of life care plans did not always record the personal information that would help staff to support people in the way they wished at the end of their life.

Complaints had not been fully recorded and responded to and had not been used to improve service provision.

Staff had a good understanding of their responsibilities in relation to safeguarding people. However, safeguarding concerns raised by health and social care professionals were not always recorded to make sure changes in care were made and lessons were learned.

Meaningful activities that directly reflected people's interests were not in place to make sure people's social and emotional needs were responded to. This is an area that needed further improvement.

Written communication to give people the information they needed was not available in accessible formats to make sure people could understand and make decisions. This is an area identified as needing to improve.

Enough staff were employed and available to meet people's needs. Safe recruitment processes were followed to make sure only suitable staff were employed. Staff were provided with regular one to one supervision to monitor their performance and staff meetings to provide support and information.

Fire alarm testing and fire evacuation drills were carried out to keep people safe. All essential maintenance and servicing had been carried out at the appropriate times. The provider was in the process of redecoration to improve the environment which had been put on hold during the winter months

Accidents and incidents were recorded and monitored by the registered manager to make sure safe practice was followed.

The registered manager carried out an assessment of people's needs before they moved into the service to make sure the staff team could meet their needs.

People were complimentary about the food and had choices at mealtimes. They thought the staff were caring and friendly and told us their privacy was respected.

People, their visiting relatives and staff thought the registered manager was approachable and listened to their ideas and concerns. Regular meetings gave people the opportunity to give their views and contribute to the running of the service. Relatives meetings had been stopped due to a lack of attendance and a

newsletter was being introduced instead, but some relatives thought meetings should continue to be on offer.

The registered manager had displayed the ratings from the last inspection, in October 2017, in a prominent place so that people and their visitors were able to see them.

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.

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

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

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.

The assessment of individual risk had not been sufficiently considered and recorded. Records were not maintained to make sure people received the appropriate care.

Infection control measures were not always used by staff. A strong odour had been an ongoing concern that had not improved.

People's prescribed medicines were not managed safely.

Staff had a good understanding of their responsibilities to keep people safe from abuse. Lessons regarding safeguarding concerns raised by external bodies were not used to make improvements.

Accidents and incidents were recorded by staff and monitored by the registered manager.

Staffing numbers were sufficient to meet people's needs. Robust recruitment practices were followed.

Fire safety measures were in place to keep people safe. Servicing of equipment was carried out as appropriate.

Is the service effective?

Requires Improvement

The service was not always effective.

The basic principles in relation to the Mental Capacity Act 2005 were not always followed to make sure people's rights were upheld.

People were referred to health care professionals but the advice given was not always recorded to make sure the changes in care were followed by staff.

Staff received the basic training they required, however, additional training to meet peoples' specialist needs was not provided. Staff had the opportunity to have one to one

supervision meetings with the management team.

People were supported to eat a balanced diet and were happy with the meals prepared and choices available.

People's needs were assessed before moving in to the service and care plans developed accordingly.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with dignity and respect as their needs were not always met.

People thought the staff were kind and caring in their approach.

People were supported to maintain their independence. Staff were aware of people's privacy and respected this.

People could receive visitors when they wanted. Visitors were made to feel welcome.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were in place, however the information required for staff to provide individual care and support was not always accurately recorded.

Complaints were not dealt with effectively to learn lessons and make improvements.

People were encouraged to make plans for the end of their life if they wished to although these were not sufficiently detailed. Their cultural and spiritual needs were addressed.

People were given the opportunity to take part in some activities. The activities programme needed further enhancement.

Is the service well-led?

Inadequate

The service was not well led.

Opportunities had been missed to make improvements through the quality audit and monitoring process. Improvements had not been made over consecutive CQC inspection reports.

The recording of changes in people's care was not clearly recorded and acted upon to ensure safe care.

The registered manager did not always work effectively with other agencies to provide people with joined up and safe care.

People thought the management team were approachable and listened to their views. Staff felt they were supported and listened to.

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 27 and 28 November 2018. The inspection was unannounced. The inspection was carried out by two inspectors, an assistant inspector 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.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is information we require registered persons to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also looked at notifications about important events that had taken place in the service which the provider is required to tell us by law. We used this information to help us plan our inspection.

Safeguarding concerns had been raised by health and social care professionals before the inspection about the care provided at the service and these were still being investigated by the local authority at the time of inspection. We received feedback from two health professionals and a local authority commissioner who had recently visited the service.

We spoke with six people who lived at the service and three visiting relatives, to gain their views and experience of the service provided. We also spoke to the registered manager and four staff, including the cook.

We spent time observing the care provided in the communal areas and the interaction between staff and

people. We looked at five people's care files and the medicine administration records. We also looked at four staff files including recruitment and supervision records as well as staff training records, the staff rota and staff team meeting minutes. We spent time looking at the provider's records such as; policies and procedures, auditing and monitoring systems, complaints and incident and accident recording systems. We also looked at residents and relatives meeting minutes and surveys.

Inadequate

Is the service safe?

Our findings

At our last inspection, on the 10 October 2017, we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The administration and storage of people's medicines were not safe and monitoring processes were not effective to ensure ongoing safe management.

The registered manager sent us an action plan following the inspection, on 22 January 2018, detailing what they planned to do to meet Regulation 12. The action plan did not confirm a date when they expected to be compliant by. At this inspection, we found that although some improvements had been made to the management of people's medicines, there continued to be areas of concern. We also found that individual risks had not always been identified and assessed to keep people safe. People whose behaviour challenged others were not provided with positive support to ensure better outcomes for their wellbeing.

The processes in place for managing people's prescribed medicines were still not robust enough to make sure people received their medicines safely. We observed a member of staff administering people's medicines when they were due. Safe practices were not in use. Although the member of staff stayed with people until they had taken their medicines, they signed their name on the medicines administration record (MAR) confirming they had given people their tablets before they actually gave the medicine to them. One person was prescribed pain relief PRN (as and when necessary). The member of staff recorded the code meaning the person had refused their medicine without asking the person if they were in pain. The person was not given painkiller medicine but was not given the opportunity to say if they had any pain as the decision was taken by the member of staff. Some people were not able to have their prescribed medicines as the stock in the service had run out and new stock had not been received.

Some people were prescribed PRN medicines such as pain relief. Guidelines were not in place for some people's PRN medicines to advise staff for instance, the reasons people were prescribed the medicine and how many they could safely take in a 24 hour period.

We checked a random sample of medicines to see if the numbers of tablets left in stock tallied correctly. We found a number of medicines did not add up as they should. One person was prescribed Paracetamol and when we checked the numbers of tablets in stock with the numbers carried forward minus those signed as given, we found they were short by 66 tablets. Another person was prescribed Co-codamol PRN and they had two tablets not accounted for.

Some people had new medicines prescribed or changed by a Doctor mid cycle, so staff had to make a handwritten addition to the MAR. These were not signed by two members of staff to evidence the record made had been checked and was correctly documented as detailed on the prescription.

The failure to ensure the safe administration of prescribed medicines was also identified at the last inspection so is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The necessary checks were carried out on equipment and room and fridge temperatures taken to make sure they remained within safe limits. Some medicines need to be stored within a safe temperature range to maintain their effectiveness.

Individual risk assessments had not always been completed to mitigate the risks associated with people's specific needs. Risk assessments were missing relating to, for instance, falls and pressure areas.

Risk assessments had been completed to identify some areas where people were at risk. However, these did not always relate to people's specific circumstances and the measures needed to prevent harm. One person was assessed as being at very high risk of acquiring further pressure sores due to the poor condition of their health. Healthcare professionals were visiting regularly to dress deteriorating pressure sores. They had advised staff that the person must be moved every one to two hours, day and night. The person's risk assessment recorded that their position must be changed regularly to prevent the risk of further pressure sores and staff must check the condition of their skin every time. However, how often they should be supported to move position, as advised by healthcare professionals, was not detailed in the risk assessment. The person's position change charts showed staff had recorded each time they had supported the person to move. However, many recordings stated they were asleep or had moved independently so staff had not changed their position. This meant that the person was not always being moved one to two hourly as the professional advice given. When the person had moved independently staff did not record they had checked the condition of their skin, as detailed in their risk assessment, or checked to make sure the bed sheets were not crumpled, creating a greater risk of the person's skin breaking down further.

Another person was assessed as being at high risk of falls. An individual risk assessment had not been carried out to identify what the risks were and what staff should do to keep the person safe by preventing further falls and avoiding injury.

Staff needed to use a hoist to help one person to move from their bed to a chair and vice versa. The person was known to move around while in the hoist sling due to anxiety. Although a risk assessment was in place it did not give the guidance needed to make sure the person was assisted in the right way to prevent injury. Although the person was not able to move their legs independently, a position change chart or guidance for staff on how to prevent pressure sores was not in place.

A clear understanding of how to support people whose behaviour challenged was not evidenced. One person's care plans, in relation to their capacity to make decisions and regarding their personal care needs, were written in a negative and judgemental way about the person. A plan to describe the best way to provide consistent and positive support to the person when they became anxious or upset was not in place. Records were not in place to advise and guide staff how to provide the most appropriate care to help the person to feel more secure and less anxious. It was clear that the person had not been involved in developing their care plans to give their view on the best way to support them when they became anxious. Recording charts were in place for staff to record incidents of challenging behaviour, their response and the outcome. The charts showed that staff were not responding to challenges in a positive manner and were inconsistent in their approach, with a lack of understanding in positive behaviour support. The charts were not monitored by the registered manager, in order to review and update the care plan, by identifying the approach that had the most positive responses and outcomes. We raised our concerns with the registered manager who agreed the care plans and recording in the behaviour charts were not appropriate. However, monitoring processes were not robust and they had failed to recognise the issues, so staff had carried on responding negatively to the challenges. The registered manager told us they would develop new care plans to reflect a more positive approach.

Another person's care plan briefly referred to their frustration and that they sometimes threw things. However, there was no guidance in place to advise staff when this was likely to happen, how to support the person and what staff should to do to prevent them becoming agitated. The numbers and types of incidences had not been monitored to try to prevent further occurrences.

Some people chose to smoke a cigarette and used a small enclosed courtyard for this purpose. They chose when they wanted to smoke and asked staff to help them to open the door to the courtyard from the conservatory. Safety measures were not in place to prevent accidents. There had been a heavy rainfall on the day of the inspection visit and the evenings were dark early. Two people went outside to have a cigarette when it was dark and wet underfoot. Although there was a light in the courtyard, this had not been switched on, so people were left in the dark. One person had only their slippers on and used a walking aid to get around. A covered area was not available, so people could not stand in a dry area. We went to find a member of staff as we had concerns for people's safety. The member of staff switched the light on then went back to their duties. However, the light did not stay on, it switched itself off as it was a sensor security light. The registered manager told us the light could be switched on permanently, however, two members of staff had not made sure they had done this. The two people came back in through the door into the conservatory area where a doormat was not available to wipe their feet, causing a slip hazard with wet feet on a floor without a carpet.

Infection control procedures were not always followed to keep people safe from cross infection. Staff carried dirty laundry to the laundry bags without wearing gloves and aprons. Soap and hand sanitiser was not available in the bathroom used by staff. A holder for disposable aprons on the first floor was empty. Although staff could access these on the ground floor, if they were busy on the first floor this made it more difficult to access quickly.

The failure to ensure people were kept safe from harm is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There continued to be a strong odour in parts of the service. We identified this at our last inspection and highlighted it as an area that needed improvement. Some relatives told us they had noticed this for some time and had raised it with the registered manager, but they had not found an improvement. Health and social care professionals told us they noticed a strong odour each time they visited, and we noted this at our last inspection.

The failure to ensure the premises were free from offensive odours and to take action to improve an ongoing concern is a breach of Regulation 15 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

Staff had a good understanding of their responsibility to protect people from abuse. Guidance and advice for staff about how to report a concern was available through a safeguarding procedure. Staff described how they would raise any worries they had with the registered manager and they were aware of who to contact outside of the organisation if they needed to. However, safeguarding concerns had been raised by health and social care professionals about the standard of care provided at times. There was no evidence that lessons had been learnt from these investigations to review procedures and care provision in order to prevent further occurrences.

The people we spoke with and relatives told us they felt safe living at Phoenix Residential Care Home. The comments people made included, "I feel safe, carers are marvellous, they take really good care of me. I would speak with (Team leader) if one of the staff wasn't nice to me" and "Yes I feel safe; the girls are always

looking out for you." A relative said, "Safe in this building, carers are caring, I feel quite happy she is here and being looked after. If I had an issue with staff I would speak with (Team leader)." However, as described above, we found during our inspection visit that the service was not always safe.

At the last inspection we made a recommendation to the registered manager as people and their relatives told us staff were not always available when needed. At this inspection, people were more positive about staff availability and told us they did not have to wait long for staff to attend to their needs. One person said, "I press the buzzer for a carer to come and help me to come down in the lift. I don't wait long unless they are dealing with an emergency." The relatives we spoke with also said they felt there were enough staff. Staff told us they thought there were enough staff to meet people's needs and they did not feel under pressure.

At the last inspection we made a recommendation to the registered manager as a large young dog belonging to the deputy manager was regularly in the service. A risk assessment had not been completed to make sure they were safe around people. At this inspection, the dog was no longer visiting the service.

Accidents and incidents were recorded by staff. Post fall observations had been carried out by staff when no obvious injury that required a visit to the hospital or call to the GP was found. The registered manager completed an audit and analysis of all incidents, taking preventative action where necessary. For example, people had been referred to a specialist falls team when the registered manager had identified through monitoring that people had fallen three times.

Staff recruitment records reviewed showed all the relevant checks had been completed before staff began work. These included disclosure and barring service (DBS) checks, evidence of conduct in previous employment and proof of identity. A DBS check highlighted any issues there may be about staff having criminal convictions or if they were barred from working with people. Staff did not start work until these checks had been completed. Staff confirmed they had been required to provide all the relevant documentation before they started working for the provider. This helped to ensure staff employed by the service were suitable to work with the people they cared for.

Each person had a personal emergency evacuation plan to support their safe evacuation in the event of an emergency. Fire alarm tests were carried out regularly and fire evacuation drills had been practiced and recorded. Staff confirmed they had taken part in fire drills. All essential works and servicing were carried out at suitable intervals by the appropriate professional services including, fire alarms and equipment; gas safety; electrical safety; lifting equipment; legionella testing.

Requires Improvement

Is the service effective?

Our findings

At our last inspection, on the 10 October 2017, we found a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's individual needs regarding weight loss and food and fluid intake were not always met.

The registered manager sent us an action plan following the inspection, on 22 January 2018, detailing what they planned to do to meet Regulation 9. The action plan did not confirm a date when they expected to be compliant by. At this inspection, we found that Regulation 9 was met. However, people's care records were not accurately maintained to evidence that the advice given by health care professionals was being followed. We found further areas of concern regarding people's rights within the principles of the Mental Capacity Act 2005 and staff not receiving the required training to fulfil their role.

People had often been referred for advice from a health care professional when their health or wellbeing was causing concern. GP's, district nurses, dieticians, chiropodists and dentists had been contacted by staff. A record was kept of health and social care professional's visits to see people with the date of their visit and the reason. A relative said, "[Loved one] recently complained of a sore throat and feeling unwell, the doctor was called out straight away, prescribed antibiotics and I was told as soon as I arrived on a visit." However, people's records were not always updated with the advice and guidance given.

One person had been visited by a dietician who gave specific advice around the person's food and fluid intake which was crucial to maintaining their deteriorating health. Their care plan had not been updated. The person had a catheter in place and the care plan advised staff to give drinks regularly. It did not say how much fluid the person needed within the day to prevent the risk of dehydration. The care plan guided staff to give the person what they fancied to eat. It did not advise staff that their food should be fortified with fats, sugar and cream to prevent the risk of malnutrition, as advised by the dietician. The person's food and fluid charts had been completed but did not show that they received the amounts of food and fluid advised. Sometimes they had 1000mls of fluid in a day and other times only 300mls with no explanations given. Staff did not record if they had fortified the person's food as advised or if they had offered food again if the person had refused to eat at mealtimes. The registered manager had not identified this by checking that the person was receiving the safe care advised to prevent further deterioration of their health.

The failure to ensure complete and accurate records are maintained is a breach of Regulation 17 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 they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People had given their consent for staff to provide their personal care and to administer their medicines by

signing a consent form. Where appropriate family members had been involved. A number of people living in the service had been diagnosed as living with dementia. A capacity assessment had not been completed for any person living in the service to check if they understood what they were giving their consent to and could retain that information. No best interest's decision-making process had been followed or recorded. Some people had signed consent to receiving care and treatment when they had been assessed as not having the capacity to make this decision. One person had signed their consent to receiving care at Phoenix Residential Care Home on 5 June 2016. They had a DoLS authorisation dated May 2018 which meant they had been independently assessed as not having the capacity to make decisions about living in the service and receiving care. Their care plan had not been updated to reflect the changes in their care and to make sure staff understood some decisions may need to be made in their best interest's. A best interest's decision-making process had not been taken to show how decisions had been made when people were assessed as lacking capacity to make some decisions.

The failure to ensure people's rights were upheld within the basic principles of the Mental Capacity Act 2005 is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. The registered manager had made DoLS applications to the appropriate authorities when people living in the service may not have the capacity to consent to their care.

At the last inspection we made a recommendation to the registered manager as staff had not received training in specific topics to make sure they had the skills to provide the care they were undertaking. Staff were carrying out blood pressure checks and had not received any training to carry out this task. Staff had not received diabetes training when they were providing care and support to people with diabetes. At this inspection staff had still not received training in diabetes awareness or to take people's blood pressure. The registered manager told us they had asked local health care professionals to provide training to staff to take blood pressures, but they were unable to do this. The registered manager confirmed they had agreed to continue to monitor the blood pressure of all people living in the service as it had been requested by the GP. However, staff had not been trained to carry out this medical task and had not been given guidance to alert them at what point each individual person's blood pressure may need the attention of a health care professional.

Staff told us they received the training they needed to carry out their role and had been given the opportunity to undertake vocational qualifications relevant to their role. These included NVQ's and diploma's in health and social care. The registered manager carried out most of the training with staff and staff confirmed this. The registered manager told us they had been trained to provide staff training in a number of areas. The training plan showed staff had received basic training. However, it also showed one new member of staff had undertaken 11 training courses in one day which is a significantly high amount of training in such a short time to be able to gain the knowledge and skills required. Staff had not received other specific training to meet people's individual needs, including challenging behaviour training, to learn the skills to understand people's behaviour and to support them in the most appropriate way. This was an area of practice we found needed improvement as reported earlier in the Safe domain of this report. Staff had not received catheter care training when they were providing care and support to people with a catheter in place.

The registered manager told us a casual member of staff who stood in for the registered manager when they were on leave carried out pressure area care training with staff. The registered manager said the member of staff was a trained nurse and had assured them they were suitably qualified; however, they could not confirm if the member of staff was qualified to provide training as they had not seen a certificate to verify this.

The failure to ensure staff have the skills and knowledge to provide care and support to meet people's needs is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us the staff knew how to support them. The comments people made included, "Staff use the sling hoist to get me in and out of bed. It's a bit of a performance but I've got used it now"; "Staff know I like doing most things for myself and because of my eyesight I only want their help to come downstairs in the lift" and "In the evening I come back to the lounge to be with the others after watching the soaps. If I am hungry the night staff, make me a peanut butter and jam sandwich and I'll go back to my room around 11pm to watch TV before I go to bed." However, people's records were not accurately maintained to evidence this, as described.

The registered manager had a plan in place for redecoration. This had started, some areas had been completed and some were ongoing. The work had been put on hold for the winter to make sure paint fumes did not create a problem for people. The lounge area was small and crowded. Many people spent time in their rooms. If all the people living in the service wished to sit in the lounge this would be difficult. The registered manager told us they had plans to refurbish the conservatory area, making it accessible all year round, which would increase the comfortable areas for people to sit in and socialise.

The registered manager carried out an assessment with people before they moved in to the service. The assessment covered the person's needs in relation to their, personal care; eating and drinking; mobility; cognition and medical history, identifying what support was needed and this was used to develop the care plan. Information from other sources such as assessments by health or social care professionals were also used. This enabled the registered manager to make an informed decision that the staff team had the skills and experience necessary to support people with their assessed needs.

At the last inspection we made a recommendation to the registered manager as people told us there had not been a regular cook working in the kitchen for some time. They said this had a detrimental effect on the quality of food and range of meals. At this inspection we found this had improved and a regular cook was now in position. People were happier with the meals provided. The comments we received included, "Meals are always good and always tasty" and "Beautiful. Often get a choice of vegetables, cabbage, carrot or mixed veg."

People were given a choice of two meals and the cook told us people could ask for another alternative if they did not want either of these. They gave us an example of one person who was unwell and so their appetite was poor. They were asked what they fancied to eat, and they said salmon and new potatoes, so this was made for them. People could choose to eat their meal in the dining room or in their bedroom. People who chose to eat in the dining room could choose where they sat, and many chose to sit with friends. One person's care plan said they preferred to eat their meal in the conservatory and they ate their meal there as described during the inspection visit.

Requires Improvement

Is the service caring?

Our findings

At our last inspection, on the 10 October 2017, people had mixed views about the caring attitude of staff as some people told us some staff were not always caring towards them. The conservatory area was used as a dining room and was noticeably cold. People were also feeling the cold when sitting in the lounge, which was next to the conservatory area. The registered manager told us at that inspection that they planned to move the dining area out of the conservatory and into a room that was available as a second lounge but not being used. At this inspection we found the dining area had been moved to a more suitable arrangement and people were happier with this. One person said, "The dining room has been changed from the conservatory to here. Lovely big windows and we can see who is coming in."

People gave more positive feedback about the staff attitude at this inspection. The comments we received included, "Staff are kind and caring, the way they look after us, always ask how I am. I love them, I can have a laugh with them"; "Marvellous, couldn't get any better, always laugh and joke, carers don't treat us as old people, we are the same as them" and "Very caring, they show that they care, they always try to help."

Although people were more positive about the staff team and how they were supported, we found that people were not always treated with dignity and respect as shown through this report. For instance, the registered manager had not made sure that people who had specific and complex needs had been cared for as advised by healthcare professionals; people who required positive support from staff to manage their anxieties did not always receive this support; an odour continued to be present within the service despite this being raised at the last inspection and by relatives.

Staff told us they thought people were well cared for. One member of staff said they always thought about people as they would their mum or grandmother and made sure they treated people in this way.

People told us that staff respected their privacy. For instance, staff knocked on people's bedroom doors and waited for a reply before entering and addressed them with respect. Among the comments people made, one person said, "Staff always knock and call out my name." Male staff were working in the service and people told us they were given a choice whether they had male or female staff to provide their care, "There is a male carer, I told the staff I preferred a female carer to help me when I have a shower" and another person said "(A male staff member) asked me if I minded having him help me. Not an issue for me."

Staff described to us how they maintained and respected people's privacy. One staff member said, "I make sure I close the door if in the toilet or in their bedroom, I try and keep people covered up as much as possible when I am washing them. I ask if they want to do their own face if they can."

People were supported to maintain as much contact with their friends and family as they wanted. Visiting relatives told us they felt welcomed when visiting and there were no restrictions on what times visitors could call. They said, "Staff always seem pleased to see me, tell me straight away what dad has been up to" and "Always made welcome, when I visit, always offered a cup of tea."

People and their relatives told us they had been involved in developing and reviewing their care plan. One person said, "Yes I have a care plan, the team leader goes through everything, checking I am okay" and a relative told us, "Always asked to come to his care plan reviews. I am able to see and read dad's records at any time, it shows what he is eating and drinking and what mood he is in."

Information about people was treated confidentially. The registered manager and operations manager were aware of the new General Data Protection Regulation (GDPR); this is the new law regulating how companies protect people's personal information. Staff had received training to give them the basic information they needed to know. People's care records and files containing information about staff were held securely in locked cabinets or offices. Computers were password protected.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection, on the 10 October 2017, we found a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's individual care plans did not always take account of their social and emotional needs.

The registered manager sent us an action plan following the inspection, on 22 January 2018, detailing what they planned to do to meet Regulation 9. The action plan did not confirm a date when they expected to be compliant by. At this inspection, we found that Regulation 9 was now met. However, people's records did not provide a holistic view of people's care needs and were not accurately maintained to ensure the appropriate care was provided.

Care plans were in place to record the care and support people needed with their; personal care, eating and drinking, cognition, skin care and mobility. These were not always person centred, giving the detail needed to address people's individual needs. Some care plans gave the same information for different people, for example, the care plan to follow when administering people's medicines. These provided step by step guidance but not individual to each person, as they described similar guidance rather than how each person preferred to take their medicines.

Care plans were basic and did not always provide the individual information to guide staff to approach people's care in the way they wanted and had agreed. Some people had specific care needs that needed skilled input from staff to make sure they received the care they needed to remain well, safe and pain free. One person had a catheter in place. One section of their care plan, relating to toilet needs, referred to a catheter, advising staff to monitor drainage to prevent blockage and the risk of infection and advising to empty on a regular basis. However, a specific care plan to make sure the appropriate and safe catheter care was provided to the individual had not been developed. Staff had not received training in catheter care, so the registered manager could not be sure that the person's needs were met, and they were receiving safe care.

Another person was at high risk of acquiring pressure sores as they had restricted movement. An individual care plan or an assessment of the risks of their skin breaking down was not in place to make sure the person received the care and support needed to maintain their skin integrity. Health and social care professionals had raised on more than one occasion that people's skin care was not always well maintained, and their advice was not always followed. The registered manager had not learnt from this feedback by reviewing the format of care planning and identifying risk.

People's care plans did not have a date to record when they were written and did not have the names of the staff who had written them. This meant the registered manager could not check that information provided was current and up to date or which staff were responsible if they were not.

Although some people had an end of life care plan in place to record their wishes, these gave little information, only if they wanted to be buried or cremated and the name of the funeral service they had

chosen. Religious and cultural needs were not always detailed or where people chose to be or who they wanted with them at the end of their life. Some care plans had not been fully completed and some not completed at all.

People's care plan records did not document the person centred detail to make sure the care and support people needed to maintain their health and well-being was understood and provided by staff.

The failure to ensure complete and accurate records are maintained is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we made a recommendation to the registered manager as the evidence was not available to show informal complaints had been suitably dealt with. A process was not in place to show how lessons had been learnt from the complaints received. At this inspection, we found that this was still an issue, changes had not been made.

Complaints were not effectively dealt with. One complaint had been recorded in the last 12 months. A relative had complained about their loved one's care. The action taken as a result of the complaint was negative and did not show that any lessons had been learnt to benefit people and improve the service. For example, one part of the relative's complaint was that their loved one's room smelled of urine. The management investigation record stated under, 'action taken', 'Room did not smell of urine, we have monthly audits', and the outcome of the complaint stated, 'I did not agree with the complaint'. A number of 'grumbles' had been recorded and as they had been considered as informal complaints, had not been investigated and responded to within the providers' complaints procedure. The grumbles were complaints but not treated as such, including, relatives complaining of their loved one wearing another person's clothes; other people wearing their loved one's clothes and a room with a strong odour. There was no evidence to suggest lessons had been learnt from these complaints to make sure improvements were made where necessary for the benefit of people living in the service. Some of these were similar concerns we had seen at the last inspection, such as ineffective laundry processes meaning people's clothes were mixed up. Some of these concerns had continued to be raised by relatives so had not been resolved, such as the strong smell of urine, which we identified as continuing during our inspection visit.

The failure to ensure complaints were investigated and responded to fully and the opportunity to learn lessons to improve the service is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a complaints procedure which gave the relevant information about who to make a complaint to and where to go outside of the organisation if they were not happy with the response to their complaint. People told us they knew who they would speak to if they had a complaint. One person said, "Just moans, no complaints, I would speak with (Team leader) if I had an issue." One relative told us, "No complaints. If I had one I would speak with a member of staff or (Registered manager). If no joy I would speak with the council."

A full time activities coordinator was not in post. The registered manager told us they had tried to recruit to the position but had not been successful. The cook had agreed to do activities three afternoons a week for two hours each time. They tried to take some people out once a week, to the shops or for a walk. At the last inspection we raised a concern about the use of a young apprentice having the responsibility of providing activities that met people's needs and interests. At this inspection, the apprentice in that role had now successfully moved into a caring role. The registered manager said they again planned to take an apprentice from a local college to act as activities coordinator. During the morning, once people had got up and had

breakfast, a member of staff stayed in the lounge area. However, they stood by the doorway to keep a check on people but did not take the opportunity to chat with people or do an activity. People were often not meaningfully engaged to meet their social and emotional needs. This is an area identified for further improvement.

External entertainment providers visited the service to offer activities such as musical entertainment and creatures such as insects to show people. The cook was providing activities on the afternoon of the inspection visit and was supporting people to play bingo. People were enjoying the game and were given plenty of time to mark the numbers themselves without being rushed. Winners were rewarded with a prize and were able to choose from a selection of snacks. One person commented, "I like playing bingo, there is a man who come comes in with his guitar and plays and sings with us" and another person said, "We had some children join us, great time they were lovely. I like the bingo I usually do a game for (name) as she cannot see the numbers. I often win a prize."

People told us that although religious ceremonies or prayers were not held in the service on a regular basis, they were able to make their own arrangements or ask one of the staff to assist in contacting their preferred church. One person told us, "Recently I told the staff I would like a local priest to visit me and staff arranged the visit."

At the last inspection we made a recommendation to the registered manager as staff were documenting people's daily records in a hardback notebook and the records were not written contemporaneously. At this inspection, the registered manager had changed the documents used for daily recording which provided a more accurate and contemporaneous record.

The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Much of the information provided for people was not in an accessible format. For example, menus were not shown to people who struggled to understand written or verbal descriptions in a format they may understand, such as photographs of meals. This is an area identified for improvement.

Inadequate

Is the service well-led?

Our findings

At our last inspection, on the 10 October 2017, we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Effective systems were not in place to monitor the quality and safety of the service.

The registered manager sent us an action plan following the inspection, on 22 January 2018, detailing what they planned to do to meet Regulation 17. The action plan did not confirm a date when they expected to be compliant by. At this inspection, we found that although the registered manager had introduced an improved auditing system since the last inspection, these had not identified the areas we found as needing improvement during this inspection.

The registered manager completed a range of audits each month. These included, a walk around check looking at cleanliness and observing the care people received; infection control; medicines; moving and handling procedures; the dining experience; wound management; maintenance; weights; activities; complaints and staff records. Although the registered manager had stated in their action plan, regarding the breach of Regulation 17 at the last inspection, 'Action plans are now in place and follow up actions completed in relation to audits'. We found that actions needed had not always been completed.

Action plans had been completed following some audits to record what action was necessary and when completed. The auditor had not always followed up to make sure improvements had been made where necessary. Some audit records showed that issues had been ongoing for some months without being rectified. Every monthly medicine audit since July 2018 had stated that staff were not recording correctly when they were giving people their 'as and when necessary' medicines. Staff were not signing to say whether they had given one or two tablets of Paracetamol for example. As this had not been addressed fully with staff to make sure improvements were made, this meant that people may not be receiving the correct dose of their tablets. The registered manager could also not ensure an accurate account of stock was kept. This is an area we found to be of concern as reported in the Safe domain of this report.

Care plans were monitored as part of the monthly registered manager's audit. However, this was a tick box exercise that was not robust enough to identify where care plans had not been fully completed or updated. The registered manager told us they did fully check care plans every two months, however they did not record this, therefore there was no evidence to support this. The areas we found as needing improvement through this report, such as changes in care advised by health care professionals, the careful following of advice given by health care professionals and the management of risk, had not been picked up and addressed.

People were found to be at increased risk of pressure sores and falls as reported. Staff were not moving people as advised by healthcare professionals to prevent a further deterioration of their skin integrity and their health. Similar safeguarding concerns around pressure area care in the service had been raised earlier in 2018. However, the registered manager had not used the learning from these investigations to ensure staff had the necessary education or guidance to manage the risks. They had not introduced closer monitoring

systems to prevent further risk of harm.

People whose behaviour challenged others were at risk of receiving inappropriate care and support as care plans did not focus on a consistent and positive approach. Care plan audits were not detailed enough to assure the registered manager that people were receiving the care they had been assessed as needing and updated when their needs changed. The registered manager had not monitored the interventions recorded by staff to improve the practices used and create positive outcomes.

Staff had not had specific training to make sure they had the skills to meet people's specialist care needs. The registered manager had continued to request that staff take people's blood pressures, a health care related task, without the training to do so, despite a recommendation about this in the last report. The registered manager had been aware that a strong smell of urine was present within the service, through various sources, including the last CQC report and this had not been rectified. The registered manager did not have the evidence to show they had learned lessons through complaints received or concerns raised by other agencies about the provision of care.

The registered manager/provider did not have a clear oversight of the care and support provided to people. The management and leadership to make sure clear guidance was in place for staff to provide safe care was not evidenced. The registered manager/provider had failed to improve the rating of the service. This was the fifth CQC inspection to be carried out at Phoenix Residential Care Home since the first report was published in February 2015. The registered manager/provider had not yet achieved a Good rating. The service had been rated Inadequate twice and Requires improvement twice in that time. This is therefore the third rating of Inadequate since February 2016.

The failure to ensure a robust approach to improving the quality and safety of the service is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had made contact with other local providers and engaged with local authority commissioners and staff as well as some health care professional such as GP's. Three health and social care professionals raised concerns regarding the quality of care provided and told us the registered manager and staff did not always fully engage with them which they felt had an impact on some elements of people's care, such as pressure areas.

People told us they found the registered manager was approachable and they felt they were listened to. The comments we received included, "If you want to speak with the manager she is there for you"; "(Registered manager), you couldn't get any better she always gives you time if you want to speak about things" and "Staff do listen when you call for their help, sometimes they don't have time to chat as they are always busy." A visiting relative told us, "The manager is approachable, I have had a few chats about mum's health" and another said, "I have suggested improving the garden, so people can sit out there in the summer. I have been told me that this is on their plans."

Regular meetings were held with people who lived at the service, giving them the opportunity to be involved in some decisions about the running of the service. The type of activities people wanted to have was discussed regularly as well as the food and menu choices. Staff spoke to people individually to get their views if they were unable, or did not wish, to join the main meetings. One person said, "We were asked what we think of the decorating. They have bought some new pictures to add to the walls." The registered manager had organised relative's meetings, to be held once every three months. No relatives had attended the last two meetings, so the registered manager had decided to try a newsletter instead to see if this would be more beneficial. However, some of the relatives we spoke with felt the option to attend a meeting should

continue to be made available as it gave the opportunity for a two-way conversation if there were areas to address.

Staff told us the registered manager and management team were supportive and approachable. One member of staff said, "I love it here and would not want to work in another care home." Another member of staff commented that they had found the service to be family orientated compared to other care homes they had worked in.

The registered manager held regular staff meetings to keep staff up to date and share concerns and ideas. The registered manager used the opportunity to give coaching sessions to check staff understanding of various subjects. Staff were able to share ideas or raise concerns.

The registered manager was also the provider and knew the service well. The registered manager understood that they were required to submit information to the Care Quality Commission (CQC) when reportable incidents had occurred. For example, when a person had died or had an accident. All incidents had been reported correctly but were not always sent without delay as expected.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed their rating in the front door lobby of the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure people's rights were upheld within the basic principles of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider failed to ensure continuing unpleasant odours within the service were identified and rectified.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider failed to ensure complaints were investigated and responded to fully and to take the opportunity to learn lessons to improve the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure staff had the skills and knowledge to provide care and support to meet people's needs.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure the safe administration of prescribed medicines and to ensure people were kept safe from harm.

The enforcement action we took:

We served a warning notice telling the provider to make improvements by a specified date.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to keep accurate and contemporaneous records and to effectively monitor the quality and safety of the service.

The enforcement action we took:

We served a warning notice telling the provider to make improvements by a specified date.