Prime Life Limited

Phoenix Park Care Village

Inspection report

Phoenix Avenue
Off Phoenix Parkway
Scunthorpe
Lincolnshire
DN15 8NH

Tel: 01724289885
Website: www.prime-life.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Phoenix Park Care Village is a purpose build home situated on the outskirts of Scunthorpe. It is registered to provide accommodation for people who require nursing or personal care for a maximum of 111 people.

The service is separated into two units, Hilltop and Overfields. Hilltop offers 77 single, en-suite rooms for older people some of whom may be living with dementia, complex health conditions requiring nursing care and behaviours that may challenge the service and others. Overfields provides 34 single en-suite rooms for younger adults with complex needs and mental health conditions. The service offers a number of communal lounges, conservatories, kitchens, a mixture of dining and bistro areas, games rooms, hairdressing and beauty salon, landscaped gardens and outdoor seating areas.

At the time of this comprehensive inspection, there was no registered manager in post. Two managers who worked at the service had applied to become registered and completed their 'fit persons' interview with a Care Quality Commission (CQC) registration inspector but the application process was still in progress. A registered manager is a person who has registered with the CQC 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.

We carried out this unannounced comprehensive inspection of the service on 1, 2 and 8 September 2016 to check that the registered provider was now meeting legal requirements and had achieved compliance with the regulations identified in breach at the comprehensive inspection on 17, 25 & 28 September 2015 and the focused inspection on 27 & 28 January and 12 February 2016.

At the comprehensive inspection of the service on 17, 25 & 28 September 2015, we found the registered provider was non-compliant with regulations 9, 10, 11, 12, 13, 17 and 18 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. This meant the registered provider was not meeting the requirements of regulations pertaining to providing person centred care, treating people with dignity and respect, obtaining appropriate consent and following the principles of the Mental Capacity Act 2005, providing safe care and treatment, safeguarding people from abuse and improper treatment, utilising effective systems to monitor and improve the quality of service provision and ensuring staff had the skills, abilities and support to meet people's needs.

At the focused inspection on 27 & 28 January and 12 February 2016 we found the registered provider had failed to take appropriate action to achieve compliance with any of the regulations identified during the previous inspection in September 2015. We also found evidence that the registered provider was in breach of regulation 19. This meant the registered provider was not meeting the requirements of regulations pertaining to employing fit and proper persons.

After the focused inspection on 27 & 28 January and 12 February 2016 the registered provider contracted the

support of a management company to help them make the required improvements and ensure they achieved compliance with the regulations.

At the previous inspections of the service, we found that people did not always receive person-centred care. During this comprehensive inspection we found that some people's care plans were up to date, reflected their current care and support needs and provided appropriate guidance to enable staff to support people effectively. However, some care plans contained contradictory information, did not reflect people's current care and support needs or contain adequate guidance to ensure they were supported consistently and in line with their preferences.

We also found that there was more than one format or style of care plan in use at the service, which meant staff may have found it difficult to find information in a timely way. A regional director informed us that an internal action plan had been created and that the service would have all care plans up to date using the chosen format and style by 15 October 2016. This was an on-going breach of regulation 9.

At the previous inspections of the service, we found that people were not always treated with dignity and respect. During this comprehensive inspection we observed numerous positive interactions between people who used the service and staff. Staff spoke to people clearly and at a suitable pace as well as giving people time to respond before supporting them with the choices they made. People were supported to take part in activities as a group and individually.

At the previous inspections of the service, we found that consent was not always gained before care and treatment was provided and the principles of the Mental Capacity Act 2005 (MCA) were not followed when people lacked the capacity to make informed decisions themselves. During this comprehensive inspection we found that the registered provider had made satisfactory improvements in this area, meetings were held to ensure decisions made on people's behalf were made in the person's best interests and in line with their known wishes. Throughout the inspection we heard staff gaining people's consent before care and treatment was provided.

At the previous inspections of the service, we found that people did not always receive safe care and treatment. During this comprehensive inspection we found medicines were managed safely; PRN [as required] medicine protocols were clear and provided relevant information to enable staff to understand when and why they should be administered. However, some infection prevention and control practices increased the risk of healthcare related infections spreading throughout the service and effective monitoring of people's needs did not always take. Risks were not always appropriately mitigated and some care plans did not contain appropriate guidance to enable staff to manage people's behaviours that challenged the service and others. This was an on-going breach of regulation 12.

At the previous inspections of the service, we found that restraint and physical interventions were used in a dis-proportionate way and we saw least restrictive practice was not always followed. Effective action was not taken to analyse the number of incidents that occurred and subsequently learning was not achieved and appropriate action was not taken to prevent their re-occurrence. During this comprehensive inspection we reviewed the number of incidents that occurred and saw a significant reduction since our last inspection. Records showed staff had been trained to carry out physical interventions safely.

At the previous inspections of the service, we found that the registered provider had failed to operate good governance systems in the service. During this comprehensive inspection we found a time specific action plan had been created with the management company employed by the registered provider and weekly meetings occurred, which were attended by the registered provider's nominated individual, regional and

quality directors as well as a representative from the management company. Completed actions were signed off after their completion. However, two significant areas were still outstanding, the completion of appropriate and accurate care plans for each person who used the service and staff training, mentoring and support. We found that the reviewing of care plans failed to highlight errors and inconsistencies, auditing failed to ensure infection prevention and control working practices were effective and risks were managed appropriately. This was an on-going breach of regulation 17.

At the previous inspections of the service, we found that people were not always supported by adequate numbers of suitably trained and experienced staff. During this comprehensive inspection we found staff were not trained in line with the registered provider's policies and had not received effective and consistent supervision and appraisal. This was an on-going breach of regulation 18.

At the last inspection, we found that recruitment practices were not established and operated effectively. During this comprehensive inspection we saw evidence to confirm, before prospective staff were offered a role in the service appropriate checks were undertaken. The staff files we saw showed staff had been recruited safely and any gaps in their employment history had been explored.

People who used the service were encouraged to take part in activities of their choosing and staff encouraged people to make choices in their lives and maintain their independence.

People were provided with a wholesome and nutritious diet. We saw that a minimum of two choices were offered for each meal and fresh fruit and snacks were available for people throughout the day. When concerns with people's nutritional intake were highlighted, action was taken including gaining the advice and support from community dieticians and the Speech and Language Therapy team.

People's private and confidential information was stored and handled appropriately.

The registered provider had a complaints policy in place and information regarding how to raise concerns was displayed within the service. We saw evidence to confirm when complaints were received they were investigated and responded to in line with the registered provider's policy. Learning from complaints was used to drive improvement across the service when possible.

When accidents, incidents and other notifiable events occurred with the service, the CQC and local authority teams were informed without delay.

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?

Requires Improvement

The service was not consistently safe. Parts of the service were not always cleaned effectively and infection prevention and control practices increased the risk of spreading healthcare related infections throughout the service.

Appropriate action was not always taken to mitigate known risks to people's health, safety and welfare.

People were not always supported by adequate numbers of suitably trained staff.

Medicines were ordered, stored and administered safely. People received their medicines as prescribed.

Staff were recruited safely after appropriate checks were completed.

Is the service effective?

Requires Improvement

The service was not consistently effective. People's care plans did not always reflect their current needs and contained contradictory information. Not all of people's needs were effectively planned for.

Staff had not received effective levels of support, supervision, appraisal or professional development.

The principles of the Mental Capacity Act 2005 were followed and consent was gained before care and support was provided.

People were supported to eat a healthy diet of their choosing.

People were supported by a range of community healthcare professionals, whose advice and guidance was implemented by staff.

Is the service caring?

Requires Improvement

The service was not consistently caring. On occasion staffs actions did not show respect for the people who used the service.

Relevant information about people was not always available to ensure staff could engage with people in a meaningful way.

People were listened too and their choices were respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. People's care plans were not always updated to ensure staff had up to date guidance and information to meet people's changing needs.

The registered provider had a complaints policy in place and investigated and responded to complaints when required.

Is the service well-led?

Requires Improvement

The service was not consistently well-led. There was no registered manager in place at the time of our inspection, which is a requirement of the registered provider's registration.

Although improvements had been made to the governance arrangements within the service, inconsistencies in care planning and other areas for improvement were not always highlighted by internal auditing.

The Care Quality Commission was notified of specific events that occurred in the service as required.

Phoenix Park Care Village

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 registered provider was 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 ensure improvements had been made since our comprehensive inspection in September 2015 and focused inspection in January and February 2016 and to provide a rating for the service under the Care Act 2014.

This comprehensive re-rating inspection took place on 1, 2 and 8 September 2016; it was unannounced. On the first day of the inspection, the inspection team consisted of three adult social care inspectors and an inspection manager. On the second day, two members of the local authority quality team supported the inspection. The third day was completed by an adult social care inspector.

Before this comprehensive inspection, we spoke with the local authority safeguarding and commissioning teams to gain their views of the service. We reviewed all of the information we held regarding the service and the action plan sent to us by the registered provider. This outlined the action they had taken regarding the shortfalls and areas of non-compliance we had identified at our previous inspections.

During the inspection, we used the Short Observational Framework Tool for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed staff interacting with people who used the service and the level of support provided to people throughout the day, including meal times.

We spoke with six people who used the service and seven visiting relatives. We also spoke with the two managers, the nominated individual, two regional directors, the registered provider's 'Quality Matters' director, two members of the quality matters team, a deputy manager, the clinical lead, the hotel services manager, three nurses, three team leaders, 10 care staff, members of the domestic team and two people who worked in the kitchen.

We looked at the care records for 10 people, including their initial assessments, care plans, reviews, risk assessments and medication administration records (MARs). We looked at how the service used the Mental

Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) to ensure that when people were assessed as lacking capacity to make informed decisions or when they were deprived of their liberty, actions were taken in their best interest.

We looked at a selection of documentation pertaining to the management and running of the service. This included the action plan created with the supporting management company, quality assurance audits, stakeholder surveys, minutes of management meetings, recruitment information for six members of staff including any professional registration details, staff training records, policies and procedures and records of maintenance carried out on equipment. We also completed a tour of the entire premises to check general maintenance as well as the cleanliness and infection control practices.

Requires Improvement

Is the service safe?

Our findings

At the comprehensive inspection on 17, 25 & 28 September 2015 and the focused inspection on 27 & 28 January and 12 February 2016, we found people did not always receive safe care and treatment. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection, we found evidence confirming, the registered provider had failed to make satisfactory improvements in relation to the requirements of Regulation 12 described above. This meant that the registered provider continued to be in breach of this regulation.

At the comprehensive inspection on 17, 25 & 28 September 2015, we found areas of the service were not cleaned effectively. At the focused inspection on 27 & 28 January and 12 February 2016, we were supported by two specialist infection prevention and control nurses form North Lincolnshire Clinical Commissioning Group. Their report highlighted both parts of the service [Hilltop and Overfields] were rated as amber and stated 'some improvement required'. The report indicated numerous concerns about cleanliness, staff practices and inappropriate storage of bags of soiled linen.

During this inspection, we completed a tour of the service and noted red bags containing soiled linen were left in people's en-suite bathrooms. The manager and deputy manager [of the building known as Hilltop] told us a new way of working had recently been introduced. They said after a person had been supported to get washed and dressed and taken for their breakfast, staff would remove any soiled linen from the bed and put it into a red bag, which would left in an open topped laundry bin until it was collected and taken to the laundry to be washed. During the tour we saw that several people did not have the laundry bins and so the red bags had been left on the en-suite floor. Extra laundry bins were purchased after the first day our of inspection to ensure one was in every en-suite.

Red bags were designed with a dissolvable seam, which would disintegrate during a wash cycle, releasing the soiled laundry into the washing machine. Leaving soiled and wet laundry in red bags in people's bathrooms could start the process of the seam dissolving which increased the possibility of infectious waste seeping out of the bag. After the inspection, we contacted the specialist infection prevention and control team from the North Lincolnshire Clinical Commissioning Group to discuss the new way of working and were informed that the practice did not follow current best practice and created an infection prevention and control risk.

On the first day of the inspection, we entered one room, which had a strong smell of urine. The manager told us the person was doubly incontinent and the room was cleaned daily. However, we entered the room on the second day of the inspection after it had been cleaned and the smell of urine was still present. There was a sheet with dried faeces on it draped across an armchair. We raised concerns with the two directors on site who provided assurance that the room would be cleaned effectively. On the third day of the inspection, we returned and the room was clean and smelt fresh. This showed that the previous cleaning regime was not effective and when the room was cleaned thoroughly on a regular basis the odours could be managed.

We witnessed an incident where a person became agitated and removed the bandages from their leg, their injury began to weep and the person scratched at the area. The person was clearly distressed and in a lot of pain, the person reached out to another person who used the service who had been sitting with them, the other person touched the first person's hand to provide reassurance. The staff tried different approaches but could reassure or calm the person, they provided sandwiches, cake and a drink for both of the people but failed to ensure their hands were cleaned effectively after touching open wounds and each other. Staff actions created an infection control risk to both of the people they provided the food to.

In another part of the service, we noted that one person's bed had been made but their pillow was stained with what looked like blood and food debris. The arm chair in their room was also stained. We saw a specialist wheelchair in an upstairs hallway that has dried faeces on it; the leather covering was ripped and required replacing. The manager told us the chair needed to be replaced and a new one had been ordered. However, the chair had not been cleaned effectively and if the person wanted to come out of their room, the chair would have been used.

The information above evidenced a breach of Regulation 12. This meant that the registered provider continued to be in breach of this regulation; we are currently considering our regulatory response to this breach and will report on any action once it has been completed.

At the focused inspection on 27 & 28 January and 12 February 2016, we found care plans, risks assessments and protocols for medicines prescribed when required (PRN) did not contain adequate guidance to enable staff to provide care and support consistently and safely or manage risks effectively. This meant that the service was not doing all that was reasonably practicable to mitigate risk, which impacted on staff's ability to provide people with safe care and treatment.

During this inspection we reviewed 10 people's care plans and found that they were not always updated when people's needs changed or followed by staff to ensure known risks were mitigated. For example, one person had sustained a serious head injury following an unwitnessed fall; some sections of their care plan were updated but discussions held between the person's relatives and the clinical lead had not been written up. Their care plan stated they needed to be monitored closely, on an hourly basis through the day and half hourly through the night. However, the plan did not include information regarding what staff were to monitor or observe and what would indicate the person's condition had deteriorated. No neurological observations were recorded or carried out and the observation records in the person's care file contained no detailed description of their presentation, alertness or indication regarding their levels of pain. We also found significant gaps in the observation records so the risks to the person were not managed appropriately.

Personal Emergency Evacuation Plans (PEEPs) were available in each care plan that we reviewed, however, the information about the person's individual support needs was not consistent with the information in other parts of their care plan. This meant that reliable and accurate information was not available ensure staff would support people effectively in emergency situations.

Access to the service is restricted; external and some internal doors lock on closure so a key code is required. We found that the codes on both sides of the service, Hilltop and Overfields had not been changed since the focused inspection on 27 & 28 January and 12 February 2016. This meant that the risk of unauthorised people gaining access to the service was not mitigated appropriately. We discussed this issue with the regional directors who took action immediately to ensure the codes were changed.

The information above evidenced a breach of Regulation 12. This meant that the registered provider

continued to be in breach of this regulation; we are currently considering our regulatory response to this breach and will report on any action once it has been completed.

People who used the service told us they felt safe. One person said, "I do feel safe now. I have had a few 'ifs and buts' in the past but it is safe." Relatives we spoke with confirmed they felt the family members were safe living at the service. A relative told us, "[Name of the person who used the service] is safe here; he gets confused and then gets angry but the staff seem to be able to pull him back to the here and now. They are very good with him."

At the focused inspection on 27 & 28 January and 12 February 2016, we found evidence confirming, people had not always received their medicines as prescribed because appropriate levels of stock were not held within the service, PRN medicines were used inappropriately, PRN protocols lacked detailed and GP's prescribing instructions had not been followed.

During this inspection, we found PRN protocols had been developed and included clear descriptions of why each medicine may be needed, when it should be given, how staff could identify it was needed and other information relating to safe levels of administration.

We checked the stock levels of medication, including controlled drugs and found that appropriate levels of prescribed medicines were available and the stock levels matched the service's records. Daily stock counts and visual checks had recently been introduced to ensure there were no discrepancies in stock levels and that all medication administrations records (MARs) had been completed accurately; there were no omissions on the MARs that we reviewed.

We observed four medicines rounds and noted these were completed safely and efficiently. Medicines were stored safely in dedicated medicines rooms. Fridge and room temperatures were recorded on a daily basis to ensure medicines were stored in line with the manufacturer's guidelines. The Nursing and Midwifery Council standards for administering and managing medicines were available for staff to refer to as required.

During this inspection, we were provided with a copy of the registered provider's dependency tool and the needs assessment of each person who used the service. The document indicated that more staffing hours were provided then the accumulative dependency needs of the people who used the service. Throughout the inspection, staff were clearly visible at all times, however, incidents occurred which highlighted issues with the staffing levels. For example, an incident occurred when a person removed a bandage from their leg and although staff were present at the time of the incident, it took over eight minutes for a nurse to arrive. On arrival they stated they had only recently started working at the service and had no knowledge of the person or the behaviours they displayed.

We discussed our concerns with the regional directors and clinical lead. The directors told us they would review the staffing levels to ensure they were appropriate and the clinical lead told us, "I am not happy with the nursing arrangements yet; we have a new nurse and are having to use agency nurses. I want to have a nurse on every floor and then one extra to support."

At the comprehensive inspection on 17, 25 & 28 September 2015 and the focused inspection on 27 & 28 January and 12 February 2016, we found people were not protected from abuse or avoidable harm. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection, we found evidence confirming, the registered provider had taken action to ensure they were meeting the requirements of Regulation 13 described above. This meant that the registered

provider was now compliant with this regulation.

At the comprehensive inspection on 17, 25 & 28 September 2015 and the focused inspection on 27 & 28 January and 12 February 2016, we found evidence confirming, people were not protected from abuse or the risk of abuse occurring, effective arrangements were not in place to ensure that appropriate decisions were made and recorded about the use of restraint, safer recruitment practices were not followed and physical interventions were carried out by staff who had not completed training to do so safely.

During this inspection, we reviewed the care plans of the people that had historically been involved in incidents or displayed behaviours that challenged the service and others. Each care plan had been written to reflect the needs of the person, they contained information including people's known triggers and signs that indicate the person was becoming agitated, de-escalation techniques that were personal and individualised and actions for staff to take. A new format had been created which utilised three strategies or support plans. This included, a green care plan which contained information and actions for staff when a person displayed 'typical behaviour'. An amber care plan included information and actions for staff when a person displayed behaviours, which indicated 'problems were about to occur'. A red care plan included information and actions for staff when a person displayed 'challenging behaviour'.

The red care plans included a description of people's behaviours such as becoming argumentative and confrontational, intimidating others, pushing or barging people out of the way, punching and kicking people and throwing items. The 'actions for staff' section failed to provide appropriate information for staff to enable them to ensure people's safety. For example, one person's care plan stated staff were to encourage other residents from the area and calmly ask the person to go to their room, if a person was displaying the behaviours such as those listed, including punching and kicking other people this guidance would not be effective.

Before this inspection we reviewed all of the notifications received from the service and liaised with the local authority safeguarding team to ensure that the information we held corresponded with theirs. During this inspection we reviewed all of the incident records within the service and found that the information we had received was consistent with that sent to the local authority safeguarding team [by the service] and the services own records. The number of incidents that occurred between people who used the service had decreased as had the severity.

We saw that the service had assessed the incidents that occurred and took action to prevent their re-occurrence. For example, one part of the service, known as the bistro, was an area where people ate and could spend time together. This area was the most frequent location for incidents to occur between people. The locked door had been opened to enable people to walk through the area and not congregate and the sofas had been removed so less people used the area at one time. This action had resulted in the number of incidents decreasing compared to what had occurred in that area previously.

During our observations, it was evident staff knew the people they were supporting, including potential triggers and how to recognise when people were becoming agitated. A member of staff we spoke with said, "I am supporting [name of the person who used the service] today, he can be aggressive and is known to make derogatory sexual remarks about woman. In the past when he was aggressive he would have been restrained; I am far too small to do that but can support him because his care plan tells me what to look out for and how to de-escalate his behaviours before they get out of hand." Another member of staff commented, "The care plans are 1000 times better than they were, you can read something [guidance to reduce someone's anxiety or agitation], try it and it actually works. They are better for us because now we know how to keep people calm and better for them because they are not angry or frustrated all the time. It's

a bit annoying because when you read it, it all seems so simple and it's like, why didn't we just do that before."

Staff confirmed they had completed safeguarding training and were aware of their responsibilities to report any potential abuse and episodes of poor care they became aware of. They were able to describe different types of abuse that may occur and told us that safeguarding people meant that they had to, "Keep people safe from many elements of harm" and "Protect others and themselves from injury or harm." They said they would report any incidents of abuse to the team leader or their manager.

We checked six personnel files to ensure that staff had been recruited safely. Each file we checked showed prospective staff were only offered a role within the service after a number of checks were undertaken. Interviews took place were experience and gaps in employment history were explored. References were requested and a Disclosure and Barring Service [DBS] check was completed to ensure the person had not been deemed unsuitable to work with vulnerable adults.

Requires Improvement

Is the service effective?

Our findings

A relative we spoke with said, "I don't know what's changed but the staff seem to be better at dealing with things. It all seems so much calmer than it used to." Another relative said, "The service has changed beyond recognition. The lady who is in charge of the training has made a fantastic change to the attitude of staff and brought warmth and cheer to Hilltop."

At the comprehensive inspection on 17, 25 & 28 September 2015 and the focused inspection on 27 & 28 January and 12 February 2016, we found the service had failed to follow the principles of the Mental Capacity Act 2005 (MCA) and ensure the rights of people who lacked capacity were protected. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection, we found evidence confirming, the registered provider had taken action to ensure they were meeting the requirements of Regulation 11 described above. This meant that the registered provider was now compliant with this regulation.

The 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 balances an individual's right to make decisions for themselves with their right to be protected from harm if they lack mental capacity to make decisions to protect themselves.

The MCA 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.

During this inspection, we spent time talking to staff about their understanding of the MCA and its principles. Staff told us they had completed training and showed us posters displayed within the service as well as cards they had been given to ensure they could refer to this information when required. Staff described how they gained consent from people, one member of staff said, "I seek verbal consent where possible and then move to visual consent. For instance I may show the person the shower or a flannel indicating a shower or a wash and they point to which they prefer. If no decision around personal hygiene can be made with a person, a best interest decision would be made in order that staff knew what to do in future."

We saw evidence to confirm best interest meetings were held when people lacked capacity and important decisions were needed to be made about their care and treatment. The best interest meetings we saw showed that a range of relevant professionals and family members or advocates attended the meeting to ensure any decisions were made in the person's best interests and in line with their previously known wishes.

Decisions regarding the covert administration of medicines were recorded in people's care files and included advice and guidance from the person's prescribing GP. We saw that one meeting had not been attended by a representative from the local authority commissioning team and raised our concerns with a

regional director. The director told us they would ensure that all relevant parties were invited to future meetings and if they could not attend a copy of the decision would be shared with them to ensure their involvement.

A person who used the service said, "They knock on my door and if my husband is here they will ask if I want them to come back later. They ask me if I want any assistance and they are always asking if there is anything I want or anything I can do." "I can wash my face. They wash the rest of me. They get me clean wipes and a towel and ask if I want to wash my face."

The quality matters director told us, "I emailed some of the things we started doing to a parliamentary member who has a portfolio including MCA after I read something in a social care blog. We have been invited to a national MCA forum to share what has been successful here at Phoenix. We have learnt a lot since the last inspections and will be implementing lots of things across Prime Life."

At the comprehensive inspection on 17, 25 & 28 September 2015 and the focused inspection on 27 & 28 January and 12 February 2016, we found people were not always supported by adequate numbers of suitably trained and experienced staff. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection, we found evidence confirming, that the registered provider had failed to make satisfactory improvements in relation to the requirements of Regulation 18 described above. This meant that the registered provider continued to be in breach of this regulation.

At the focused inspection on 27 & 28 January and 12 February 2016, we found evidence confirming staff were instructed to carry out care and support tasks that they had not been trained do so safely.

During this inspection, we found evidence confirming the registered provider had failed to ensure staff were trained in line with their own policies and procedures. The registered provider stipulated certain training was 'core training' and at least 75% of staff must have completed it. We reviewed the training records and saw core training included moving and handling, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, dementia, dignity in care, safeguarding vulnerable adults, fire safety and first aid.

The registered provider failed to ensure suitable numbers of staff had completed training in relation to, food safety, health and safety [including control of substances hazardous to health], pressure care, fire safety or first aid. This meant people were not met by appropriate numbers of suitably trained staff, which increased the risk of people not be supported safely and in line with best practice guidance.

The registered provider stipulates certain training is 'service specific training' and at least 50% of staff must have completed it. In the part of the service known as Hilltop, training such as challenging behaviour, falls awareness, meaningful occupation, mental health awareness, bed rail safety, end of life and communication were stated as service specific training. The only service specific training over 50% was challenging behaviour. The only service specific training over 50% of staff had completed in Overfields was challenging behaviour. This meant that staff may not have the necessary skills to support people with their individual needs and the registered provider had failed to ensure staff working at the service were trained in line with their own internal policies and procedures and to an appropriate standard.

The quality matters director explained, "The first thing I need to say is my team are here working with the staff on a daily basis; they are here to coach and support the team. I am confident that the staff have more knowledge that they had before, but what I can't do is show you certificates because they have not actually

done the training." They went on to say, "We are non-complaint with our own policies so know we have a lot of work to do, but we have listened to what the staff have been telling us and agreed in the management meeting with the nominated individual, now is not the time to just get staff through training, it's about making sure we are getting things right and making sure they understand the training and can come back and use it on the floor."

At the comprehensive inspection on 17, 25 & 28 September 2015 and the focused inspection on 27 & 28 January and 12 February 2016, we found evidence confirming, staff had not received appropriate levels of professional development, supervision and appraisal.

During this inspection, we found evidence confirming, staff had not received effective levels of supervision in line with the registered provider's internal policies. A manager told us, "The supervisions are a bit of a joke. Before I started 60 second learning's were used as supervisions and the annual appraisals weren't any better." 60 second learning's were used by the registered provider to check staff knowledge in specific topics, a fact sheet covering the main areas of a particular subject were given to staff to read the a set of questions needed to be answered.

We reviewed supervision audit and tracker documentation; it was evident that supervision was provided on an inconsistent basis. Records showed some staff had received up to nine supervisions in one month whilst others had not received any. Some staff had had over 10 supervisions during 2016 whilst 16 other staff had not received any.

Annual appraisals were completed on a single sheet of paper; staff were asked to rate their own attitude, attendance and ability and then their line manager made comments. We saw no evidence that the appraisals were used to develop staff abilities or to look at what further training staff had an interest in completing.

The information above evidenced a breach of Regulation 18. This meant that the registered provider continued to be in breach of this regulation; we are currently considering our regulatory response to this breach and will report on any action once it has been completed.

We spent time observing people's lunch time experience; tables were set to look homely and inviting and people chose where they wanted to eat their meals and who they wanted to sit with. People were supported by staff to choose what they wanted to eat with the use of picture menus to enable decision-making when this was required. People were offered clothes protectors and provided with effective support by staff who knew their needs. We saw a member of staff sat with one person and encouraged them to eat their meal. The person said they did not like what was on offer and refused to eat both of the meals staff brought them. Staff then supported the person to the kitchen and they chose to have sandwiches. The person's care plan indicated they declined meals and staff had followed the guidance of the dietician who advised to consistently offer alternatives and snacks as well as monitoring the person's weight.

People were supported to eat a balanced and nutritious diet that met their needs. We saw that people's dietary requirements were recorded and displayed within the kitchen. People who required soft diets had their food specially prepared and presented in a way that ensured it looked appetising. Records we saw evidenced that when people had issues with their dietary intake, relevant professionals were contacted for their advice and guidance which was implemented.

We saw people were supported by a range of healthcare professionals to meet their needs. We spoke with a community nurse who visited the service during our inspection; they told us they were impressed with the

staff's knowledge of the people who used the service and that they were contacted without delay when people's needs changed.

Requires Improvement

Is the service caring?

Our findings

At the comprehensive inspection on 17, 25 & 28 September 2015 and the focused inspection on 27 & 28 January and 12 February 2016, we found people were not always treated with dignity and respect by staff. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection, we found evidence confirming, the registered provider had taken action to ensure they were meeting the requirements of Regulation 10 described above. This meant that the registered provider was now compliant with this regulation.

At the comprehensive inspection of the service on 17, 25 & 28 September 2015 and focused inspection on 27 & 28 January and 12 and February 2016 we found evidence confirming, staff were directed to carry out specific care tasks without regard to the people's wishes or preferences, which failed to encourage staff to treat people with dignity and respect during their interactions, some people's care plans contained inappropriate language and failed to take into account the person's mental health condition when describing their behaviours and actions. Chairs and settees were rearranged during the inspection [we were told by staff this was done routinely by domestic staff so they could clean the floors] which would have been dis-orientating for people who were living with dementia and could add to their levels of confusion and agitation. During our observations we saw staff missed opportunities to engage with people and noted staff did not always communicate adequately with people or enable them to make decisions in their daily lives.

During this inspection, we observed lots of positive interactions between people who used the service and staff. We witnessed a range of activities taking place across the service including, parachute games, reading and skittles. On the second day of the inspection, we observed a number of people who are known to display anxieties and behaviours that challenged the service and others, [who were historically reluctant to engage] taking part in a karaoke session. Several people and staff took it in turns to sing and the activity was clearly enjoyed by everyone involved. On the final day of the inspection, we witnessed over 15 people sitting in the garden with staff enjoying ice cream and the sunshine. A member of staff commented on the karaoke singing, they said, "Can you remember [Name of the person who used the service] from last year? He spent a lot of time in his room, wouldn't engage and always gave yes or no answers. Look at him now, he just clicked with [name of the member of staff] and now he gets involved in all sorts; she [the member of staff] has been amazing for him."

People who used the service told us they were supported by caring staff. Comments included, "They [the staff] always make sure I am ok, they are lovely", "I am happy here, everyone is very kind" and "The staff treat us very well."

A relative commented, "The staff go above and beyond; they are wonderful and full of compassion." A second relative said, "The staff are very caring." Another relative told us, "Mum is usually in a lot of pain but the staff treat her so well; they [the staff] are very understanding and make sure she is settled."

It was apparent that more activities took place in some areas of the service than others. A member of staff we spoke with said, "We have looked at what meaningful activities there are for people and the big loud group sessions are not for everyone. Some people like one on one time, they may just want to sit and reminisce."

The atmosphere within the service was calmer and more relaxed then at our previous inspections. Work had been done to ensure the service felt more homely such as adding soft furnishings, blankets over chairs, balloons, pastel spotted bunting and pictures.

Throughout the inspection, we witnessed staff using their knowledge of people to comfort and reassure them when required. However, we observed some practice which could be improved. For example, we saw a nurse entering a person's room to deliver their morning medication. The nurse went into the room and switched on the light then left the room to collect some personal protective equipment [gloves] and returned. They checked the person's medication administration records then told the inspector they had to close the door to deliver a particular episode of care [to ensure the person was not exposed unnecessarily to anyone who passed their room]. At no point did the nurse speak to the person, acknowledge them or provide reassurance; therefore the person was not treated with dignity and respect.

We noted that one person's room had a strong odour during a tour of the service on the first day of our inspection. The smell was still apparent on the second day and we raised concerns with the regional directors. When we returned for the last day of the inspection, we checked the room and it smelt clean and fresh. This showed that the room could be cleaned effectively and previously the cleaning of the room had not been adequate. This indicated a task-based approach and showed a lack of respect to the person who used the service.

At one point during this inspection, we heard someone calling out and went with staff to see why. The person required personal care support from staff. It was clear the support should have occurred in a more timely way for them. When we reviewed the person's care plan it stated they were doubly incontinent and needed staff to regularly check on them to ensure they received the care they required in a timely way. The person had not received the care and support they required, which had compromised their dignity.

At times staffs actions were not person-centred and failed to take into account the effect they could have on people who used the service. For example, in one area of the service 'big band' music was being played at an appropriate level and we saw one person tapping their feet and another patting the arm of the sofa in time with the music. We then heard music coming from another part of the service; the music was rock or heavy metal with a deep base. This base sound carried through parts of the service and could be over stimulating for people who were living with dementia and could cause people to become anxious or agitated.

At the comprehensive inspection on 17, 25 & 28 September 2015 and the focused inspection on 27 & 28 January and 12 February 2016, we found people did not always receive person-centred care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection, we found evidence confirming, that the registered provider had failed to make satisfactory improvements in relation to the requirements of Regulation 9 described above. This meant that the registered provider continued to be in breach of this regulation.

At the comprehensive inspection on 17, 25 & 28 September 2015 and the focused inspection on 27 & 28 January and 12 February 2016, we found evidence confirming, care plans were not always updated as required, contained a range of contradictory information and failed to incorporate required or adequate

information and guidance.

During this inspection, we found evidence that some care plans continued to contain contradictory information and lacked relevant guidance to enable staff to support people effectively and in line with their preferences. Some care plans included, 'getting to know you' pages which provided personal information about people's lives before they moved into the service whilst this document was left blank in other people's care files.

The information above evidenced a breach of Regulation 9. This meant that the registered provider continued to be in breach of this regulation; we are currently considering our regulatory response to this breach and will report on any action once it has been completed.

We saw a 'dignitree' [a large cut out of a tree that staff had put dignity pledges on] was on one of the corridor walls; staff's thoughts in relation to supporting people in a dignified way were captured on comments cards and a photo collage of people who used the service participating in different activities were also displayed. This helped to focus staff in thinking about how dignity can be promoted and how people are seen as individuals with their own important histories.

During this inspection, we witnessed staff using different methods to communicate with people and heard staff explaining things to people in a simplified way to aid their understanding. We saw that advocacy posters were displayed at various points throughout the service. This helped to ensure people had access to independent support when required and would be helped to make important decisions when required.

Private and sensitive information was stored appropriately. People's care plans were kept in locked offices and access to information through IT systems was password protected to ensure only certain people had access to it. A member of staff said, "We have access to everyone's care plan but they are kept in the office's so no one ever leaves them just lying around."

Requires Improvement

Is the service responsive?

Our findings

At the comprehensive inspection on 17, 25 & 28 September 2015 and the focused inspection on 27 & 28 January and 12 February 2016, we found people did not always receive person centred care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection, we found evidence confirming, the registered provider had taken action to ensure they were meeting the requirements of Regulation 9 described above. This meant that the registered provider was now compliant with this regulation.

At the comprehensive inspection on 17, 25 & 28 September 2015 and the focused inspection on 27 & 28 January and 12 February 2016, we found people did not always receive person-centred care. Care plans were not always updated as required and the reviews that were undertaken failed to ensure accurate instructions and guidance were available to enable staff to meet people's needs. When people returned from hospital their enhanced levels of need had not been documented and their care plans were not updated. We found evidence that accidents and incidents were not used to develop people's care plans and learning had not been implemented or incorporated to provide improved information for staff which could have enabled them to meet people's needs more effectively. Advice and guidance from professionals such as mental health nurses and physiotherapists had not been followed or incorporated into people's care plans as required; people's care plans contained a range of contradictory information and failed to incorporate required or adequate information and guidance.

During this inspection, we found evidence confirming, that the registered provider had failed to make satisfactory improvements in relation to the requirements of Regulation 9 described above. This meant that the registered provider continued to be in breach of this regulation.

For example, one person's mental health care plan stated the person was physically and verbally aggressive during personal care tasks. However, their personal hygiene and dressing, care plan failed to include this information or provide staff with instructions to manage the person's behaviours or how to support them if they displayed behaviours that challenged the service and others.

Another person's care plan stated they experienced pain and staff should read their body language and facial expressions to assess if they were experiencing pain. The care plan failed to include known expressions or actions that staff had seen before which would have reduced their need to interpret the person's actions.

Care plans had been created to support people when they displayed behaviours that challenged the service and others. One person's behaviour care plan stated, "Staff may need to physically intervene if [name of the person who used the service] is at risk and/or others are in the vicinity". There was no further guidance to instruct staff how to carry out the physical interventions or what holds and techniques should be used to ensure the person was supported safely.

We saw that some people's care plans were updated following accidents and incidents to ensure their accuracy. However, we found instances where this did not occur. For example, one person's care plan stated they had historically had a sexualised relationship with another person who used the service but no sexual activity had occurred for an extended period of time. However, the incident and daily records provided evidence that this was not accurate due to sexualised behaviours being exhibited in June 2016.

A regional director told us, "I read [name of the person]'s care plan and gained an understanding of their needs, I then spoke to staff and realised the care plan made them out to be the instigator [of incidents with other people] but after discussions with staff, it was clear they weren't and they were the one being lead or targeted. We haven't got the care planning process quite right yet but we will get there." After the regional director had highlighted this issue the care plan was re-written to ensure it contained an accurate description of the person's needs and how staff were to support them.

We discussed the inconsistencies, deficits and range of formats used with regards to care plans with the regional director and highlighted the need to ensure up to date and accurate information was available for each person who used the service. The regional director explained, "We said in the action plan that we would have all the care plans fully updated and in the new format by the 15th of October [2016] and we are going to stick to that" and "We know that some of them still have some gaps, but we think overall they have improved and there is better information and guidance for the staff than there has been."

The information above evidenced a breach of Regulation 9. This meant that the registered provider continued to be in breach of this regulation; we are currently considering our regulatory response to this breach and will report on any action once it has been completed.

People were supported to follow their personal interests. To encourage people to be more engaged with their surroundings, rummage boxes, tailored to individual people's hobbies and interests, had been created. We saw personalised memory boxes had been made to help people living with dementia recognise their room and new tactile pictures were displayed. We saw some people took part in work orientated activities; one person liked to helped with the drinks trolley and another person liked to fold laundry. Staff supported and supervised people to ensure they remained safe while undertaking any activities.

The registered provider had a complaints policy in place that contained information in relation to investigation and response times and how a complaint could be escalated if the complainant was not happy with the response they received. We saw that complaints information was displayed within the service to ensure people knew how to raise concerns and make complaints.

We reviewed the complaints records and saw that when complaints were received, they were responded to appropriately in line with the registered provider's policy. The nominated individual told us, "I don't get involved in the minutiae but when accidents occur or when we get a complaint, I get informed and discuss why it happened, if it could happen to anyone else, what we have done to fix it and what have we learnt."

A person who used the service told us, "I would complain if I wasn't happy, I'd tell the world; they know I would but I can't complain, I get looked after quite well." Another person said, "I would tell the girls if I wasn't happy but I have no reason to complain thank you." Relatives we spoke with confirmed they knew how to raise concerns. One relative said, "I have complained in the past; we had issues and they needed sorting. I told the manager and things changed overnight, I was very pleased."

People who used the service and their relatives were encouraged to comment and leave feedback about the service. Posters were displayed within the service stating when the next 'residents and relatives' meeting

would take place and encouraged people to attend. A relative told us, "I get invited to meetings at the service and there are posters to remind people. The new management are willing to listen; I think that's the biggest change." Another relative said, "Lots of the relatives attended a meeting a few months back; the managers spoke about the problems and the relatives had their say, everything was noted and acted upon."

Requires Improvement

Is the service well-led?

Our findings

After the focused inspection on 27 & 28 January and 12 February 2016 the registered manager left the service. At the time of this inspection completed on 1, 2 and 8 September 2016, two managers were employed. One had responsibility for the building known as Hilltop and the second manager was responsible for the building known as Overfields. Both managers had completed their 'fit persons' interview with a Care Quality Commission (CQC) registration inspector and were waiting to be informed in they had been successful and appointed as the registered managers of Phoenix Park.

Due to the failings identified at the previous inspections, the registered provider commissioned the service of a management company, who have worked with the registered provider to create a time-specific action plan to rectify all areas of non-compliance. The nominated individual told us, "It has been very interesting working with [name of the management company], they haven't shown us anything radically different, which was pleasing but have shown us how to do things better and ensure we have evidence to support what we have done" and "My view is that this place is immeasurably different from the last time you inspected. The management team and all the staff have worked very hard and embraced the changes we needed to make." A regional director told us, "We made the decision to work with [name of the management company], and then worked together to create a plan. It hasn't always been easy; we had to listen and hear what was wrong but then created an action plan to start to move forward."

At the comprehensive inspection on 17, 25 & 28 September 2015 and the focused inspection on 27 & 28 January and 12 February 2016, we found the registered provider had failed to operate good governance systems in the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection, we found evidence confirming, the registered provider had failed to make satisfactory improvements in relation to the requirements of Regulation 17 described above. This meant that the registered provider continued to be in breach of this regulation.

At the comprehensive inspection on 17, 25 & 28 September 2015 and focused inspection on 27 & 28 January and 12 February 2016, we found care plan spot checks were ineffective; they failed ensure that care plans were accurate and reflected the people's current support needs. Care plan evaluations did not take into account accidents, incidents or other important events and were subsequently an ineffective tool to ensure care plan accuracy. Appropriate systems had not been implemented to ensure risk assessments were accurate and contained people's current support needs. We found that auditing tools were not always used effectively to improve the level of service provided, for example, the registered manager told us they did not have to check certain aspects of the audit because they knew the service contained specific facilities, this lead to audits not being completed appropriately and incorrect assumptions about standards being made. Other audits had not been effective in highlighting and rectifying the lack of compliance with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) or that staff had completed relevant training and been supported effectively.

During this inspection, we found evidence confirming, care plan evaluations continued to be ineffective, inconsistencies and errors in care plans were not highlighted by the evaluations. For example, one person's mental health care plan stating they display behaviours that challenged the service and others during personal care, their personal hygiene plan failed to include this information or provide instructions for staff regarding how to support the person when they became challenging. A regional director told us, "It's obvious the staff are just reading and reviewing each care plan, they are not reading the entire thing and picking up how one thing impacts on the other areas. That is something for us to look at and make sure we improve on."

We saw that one person's care plan stated the person was becoming more anxious and often refused personal care. We reviewed the daily records for the person and saw there had been one incident recorded during personal care delivery in the last month. A regional director commented, "I'm not sure why the care pan was updated like that; we will get that changed."

The action plan created by the registered provider and the management company highlighted that all staff supervisions needed to be up to date by 15 August 2016, but this had not been achieved and a revised deadline had not been created. We did see evidence that a supervision planner had been created but this was simply to ensure a date was planned for every other month in line with the registered provider's policy. Records showed a number of staff had not been trained in line with the registered provider's policies. The quality matters director told us the registered provider had made the decision to not send staff on further training until the new working practices had been embedded. We saw that this risk had been discussed and evaluated at a senior operations meeting where it was agreed upon. The quality matters director told us, "We could have put staff through more training, which would have meant they had a certificate but no practical understanding. My team are working with the staff and I know they have more knowledge than they have certificates. I am really proud of the staff and how they have reacted to the challenges."

A new process for the storage and management of soiled laundry had been introduced, which meant that laundry bins were required in every person's bedroom en-suite. When we completed our tour of the building, we found some rooms did not have the bins and soiled laundry was left in red bags on the floor. The lack of equipment was not highlighted in the infection control audits. After the inspection, we contacted a specialist infection prevention and control nurse who told us that the new process created and infection control risk within the service. This meant that new procedures and ways of working were introduced that were not in line with current best practice guidance and had not been adequately assessed before their implementation.

The governance systems failed to ensure appropriate action was taken to promote the safety of the people who used the service. The internal and external door security codes had not been changed for at least eight months; this meant that people could gain access to the service without the knowledge of the registered provider.

The information above evidenced a breach of Regulation 17. This meant that the registered provider continued to be in breach of this regulation; we are currently considering our regulatory response to this breach and will report on any action once it has been completed.

A regional director told us, "[Name of the management company] haven't shown us how to audit, but with some of the things they have wanted, and looking at what we weren't doing before, our auditing has become more expansive. We have used things like the accidents and incidents audits to look for patterns and have taken action, which has reduced the number of incidents that have occurred." We saw evidence to confirm that changes to seating area's and the opening of internal doors had a positive impact and had

helped to reduce the number of incidents that occurred in specific areas of the service.

We saw that team meetings were held regularly to enable staff to discuss any changes in people's health or presentation and to raise any concerns they had regarding the service. A staff questionnaire was completed in July and August of 2016 and we noted that staff's comments were positive. Staff comments on the recent changes at Phoenix Park included, "I feel the staff are being listened to and we are becoming a team again", "Having more support from the management team and being given more information into what my job role is and what I am expected to do", "The staff morale is back to a high, much more positive atmosphere. Service users all seem much happier and more content with activities", "More staff meetings with the management. More feedback for each shift on what's going good or bad or things we could improve on" and "Complaints are taken more seriously". A plan had been created to ensure feedback from staff was implemented when possible and a further survey was to be sent out in November 2016 to check the staffs thoughts on the progress.

At the focused inspection on 27 & 28 January and 12 February 2016, we found the registered provider had failed to follow the requirements of the fit and proper persons employed regulation. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection, we found evidence confirming, the registered provider had taken action to ensure they were meeting the requirements of Regulation 19 described above. This meant that the registered provider was now compliant with this regulation.

At the focused inspection on 27 & 28 January and 12 February 2016, we found evidence confirming, the systems used by the service to ensure conditions on staff's professional registrations were being met were ineffective. The service failed to ensure conditions on staff's professional registration were being met which meant if staff were failing to adhere to their professional registration the service would have not been aware.

During this inspection, we spoke with the clinical lead who told us, "As soon as I started, I checked all the PINs [nurse's registration numbers on the Nursing and Midwifery Council register] and would always check it before we offered anyone a position." A regional director told us, "We have changed the recruitment process and team leaders will interview staff as they know what they need on their floors but the registered manager will always have the final say" and "We have told them [the staff responsible for recruitment] it's not about getting anyone it's about getting the right person."

We reviewed the registered provider's accident and incident records against the information the service had provided to the CQC and the local authority safeguarding teams. From this we established that the CQC had been informed of any notifiable events that occurred as required.

As we completed a tour of the service we noted that staff recognition posters [for good practice] were displayed. The poster highlighted what action had been taken and the name of the member of staff. A member of staff said, "They [the posters] are good aren't they? It's nice when your hard work gets recognised."