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Phoenix House

Inspection report

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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?	**Inadequate**

Summary of findings

Overall summary

About the service:
Phoenix House is a care home that provides personal, but not nursing care and individual support to adults who have a primary diagnosis of a learning disability. Phoenix House can accommodate up to 11 people. At this inspection 11 people were living there.

Rating at last inspection: Good (2 April 2016). Currently rated as 'requires improvement' overall.

Why we inspected:
This was a planned inspection based on the rating at the last inspection. At this inspection we found concerns with the service provided, including breaches of the health and social care act, and rated the service as 'requires improvement.'

People's experience of using this service:
People did not always receive safe care and support. Individuals did not have comprehensive risk assessments that reflected their needs. Risk assessments were out of date and in some instances, had not been reviewed for several years.

Risk assessments had not been updated following significant incidents involving people. People did not have support plans, regarding their medicines, and there was no guidance to staff about when people should be administered 'as needed' medicines. Medicines were not stored safely.

People did not always have their rights protected by those supporting them as the provider and registered manager had not followed current guidance aimed at protecting people. The provider did not have effective care and support planning processes in place to assess people's individual needs.

People did not have holistic assessments of their protected characteristics and were not supported to maintain their own identities. People were not always supported or included in making decisions which affected them.

People were not involved in the development of their care and support plans. The care and support plans in place did not reflect people's current or changing needs and were not regularly reviewed.

The registered manager and provider did not understand the responsibilities of their registration with us. The registered manager and provider had failed to display the rating following the previous inspection as required by law. The registered manager and provider failed to make notifications to the care quality commission.

People were safe from the risk of ill-treatment and abuse as staff members had received training and knew what to do to keep people safe. The provider followed safe recruitment checks. People were supported to

eat and drink enough to maintain their health.

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

Follow up:
We will re-inspect Phoenix House within our published timescales to see what improvements have been made.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe Details are in our Safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our Well-Led findings below.	**Inadequate**

Phoenix House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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.

Inspection team:
This inspection was carried out by one inspector.

Service and service type
Phoenix House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service accommodates up to 11 people in two buildings on the same site. At the time of our visit there were 11 people using the service.

Phoenix House has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did:
Before the inspection, we asked the provider to complete a Provider Information Return (PIR). However, they failed to complete or return this as expected. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We also reviewed information we held about the service in the form of statutory notifications received from the service and any safeguarding or whistleblowing incidents, which may have occurred. A statutory notification is information about important events, which the provider is required to send us by law.

We asked the local authority and Healthwatch for any information they had which would aid our inspection. We used this information as part of our planning. Local authorities together with other agencies may have responsibility for funding people who used the service and monitoring its quality. Healthwatch is an independent consumer champion, which promotes the views and experiences of people who use health and social care services.

We spoke with three people, two relatives the registered manager, deputy manager, one support worker, one student completing work experience, the registered provider and the administration support. We looked at the care and support plans for two people including medicine administration records. In addition, we looked at quality checks completed by the registered provider and records of incidents and accidents and complaints.

Requires Improvement

Is the service safe?

Our findings

Safe – this means people were protected from abuse and avoidable harm.

RI: Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

●People had assessments of risk associated with their care and support and when going out in the community. However, those we looked at had not been reviewed since 2013. Some risk assessments were generic and not specific to the person and in one instance the risk assessment contained the wrong person's details. We could not be assured that the risk assessments reflected people's needs.

●Risk assessments had not been updated following significant incidents. For example, when one person fell, resulting in a significant injury, their risk assessment had not been updated. We asked the registered manager about this and they told us they didn't feel that it was needed. Neither the registered manager or the provider had effective systems in place to safely monitor and manage risks at Phoenix House.

●People had emergency personal evacuation plans in place which detailed the assistance they would require in the event of an emergency.

Using medicines safely

●People did not have effective care and support plans in place to promote the safe administration of medicines. For example, one person had "as required" medicines. There was no guidance for staff members on how or when to administer this medicine or how much should be taken within a 24-hour period. We asked a staff member about the administration of this medicine and they could not tell us the process they would follow in administering medicine this to the person. When we looked at the stocks of medicines this medicine was not available and the staff member told us they would need to "go and buy some."

●Medicines were not safely or securely stored.

Preventing and controlling infection

● The provider followed effective infection prevention and control practice in communal areas of the home. Staff members confirmed that they had appropriate personal protection equipment like gloves and aprons available when supporting people. At this inspection the home appeared to be clean and tidy.

Learning lessons when things go wrong

● The provider did not have effective systems in place to investigate incidents, accidents or dangerous occurrences to learn lessons to minimise the potential for harm or reoccurrence. Following a person falling and receiving a significant injury the registered provider failed to undertake an investigation into the circumstances and failed to complete a revised risk assessment or a review of the person's care and support plan. This put people at risk of harm as opportunities to examine incidents were missed.

Systems and processes

●The provider followed safe recruitment processes when employing new staff members. The registered

provider had systems in place to address any unsafe staff behaviour including disciplinary processes and re-training if needed.

●People were protected from the risks of ill-treatment and abuse as staff members had received training and knew how to recognise and respond to concerns. One person told us, "I feel safe and happy here. It's my home."

●Information was available to people, relatives and visitors on how to report any concerns.

●The provider had made appropriate notifications to the local authority to keep people safe.

Staffing levels

●People were supported by enough staff members to safely support them and to meet their needs promptly.

Requires Improvement

Is the service effective?

Our findings

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

RI:□The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

●Not all people received care and treatment in line with the law or guidance. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority.

• In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). The provider had made some appropriate applications but did not have the systems in place to identify when authorised applications needed to be renewed. We saw some applications had expired without the registered manager renewing them. This meant that people were potentially being deprived of their liberty by the provider without the legal authority to do so.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

●People did not have effective care and support assessments that reflected best practice or followed current guidance. We asked the registered manager why they had not completed the assessments of capacity for specific decisions like medicines. The registered manager told us that they had stopped doing them several years ago.

●People did not have their needs holistically assessed or reviewed. Although staff members could tell us about people's individual needs and wishes these were not reflected in their care and support plans. For example, one person had a change in their care and support needs but their care and support plans had not been updated. The registered manager could not explain why this had not been updated. This put the person at risk of receiving inconsistent care and support. Another person's support plan made reference to a medical procedure which was no longer relevant to them. We asked staff about this and they told us "If we read them (care plans) we would have picked that up but it's all out of date anyway."

●People's protected characteristics under the Equalities Act 2010 were not effectively identified or supported as part of their needs assessment. For example, we looked at one person's care and support plan. Although their background and religion had been identified there was no guidance on how to support this person retain their individual identity.

Supporting people to eat and drink enough with choice in a balanced diet

● People were supported to eat and drink sufficient amounts to maintain good health. When someone experienced unplanned weight loss or gain they were referred for professional assessment. For example, following one person losing weight they were referred for specialist intervention before their weight returned

to a healthy level.

Staff skills, knowledge and experience
● People were supported by a staff team who had received training and support to effectively assist them.
● Staff felt supported in their role and could request additional training when they needed it. Staff members undertook an introduction to their role when they first started working at Phoenix House.

Staff providing consistent, effective, timely care within and across organisations
● Staff members we spoke with were knowledgeable about people's healthcare needs and knew how to support them in the best way to meet their personal health outcomes. However, these were not effectively recorded in their care plans.

Adapting service, design, decoration to meet people's needs
● The physical environment within which people lived was accessible and suitable to their individual needs, including mobility and orientation around their home.
● People had personalised their own rooms.

Supporting people to live healthier lives, access healthcare services and support
● People had access to healthcare services when they needed it. This included foot health, GP, district nurses, opticians or audiology services. The provider referred people for healthcare assessment promptly when required. People had regular healthcare reviews to maintain good health.

Requires Improvement

Is the service caring?

Our findings

Caring – this means that the service involved people and treated them with compassion, kindness, dignity and respect

RI:□People did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care

●People were not fully involved in making decisions about their care and support or social contacts. For example, the assessments of people's ability to make their own decisions were not completed in all instances. Those that were, had not been reviewed to see if there had been a change of circumstance for people. One person had an entry in their care and support plan that stated that they could not make certain decisions for themselves regarding social contact. Decisions were therefore made by staff members supporting them. This decision was later changed and there was no assessment or consideration to account for the views of the person as part of this change in decision.

●We saw people making choices about what they wanted to do and where they wanted to go. One person told us that they had just been into town and that they chose to go in whenever they wanted to. We saw others making decisions about what they wanted to eat at lunchtime. However, one relative told us their family member loved a certain cereal at breakfast but was never provided with it or offered it as a choice. They told us that they only got this when they visited and brought it with them.

Respecting and promoting people's privacy, dignity and independence

● People told us, and we saw, that their dignity and privacy was respected. One person told us how they "took care of themselves," and only needed minimal support from staff members. They went on to say, "They (staff) are there if I need them but not often." However, one relative told us that their family members independence was compromised as staff members did not encourage their movement or complete regular exercises with them.

Ensuring people are well treated and supported

● People were treated with respect by a caring and compassionate staff team. People we spoke with described staff members supporting them as, "Nice," and "Ok." One relative said that they couldn't fault the staff supporting their family member.

● Staff members we spoke with talked about those they supported with fondness and compassion. We saw people were supported at times of upset. We saw one person started to express some anxiety. A staff member spoke with them and their anxiety appeared to ease.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means that services meet people's needs

RI:□People's needs were not always met.

Personalised care

● People we spoke with could not recall being involved in the development of their care and support plans. Relatives told us that they were not involved in discussions about their family members care and support plans.

●The care and support plans we looked at had not been reviewed for several years and did not reflect peoples changing or current needs. The registered manager said, "I haven't got around to reviewing them." One person's care and support plan stated that they did not engage in community activities. However, we saw photos of this person at café's sporting events and on holiday. The information regarding this person was inaccurate and misleading.

●Care and support plans we looked at did not accurately detail information that staff members needed to support people. The registered manager did not ensure that these were up to date or that staff members referred to them before supporting people. We spoke with one staff member who told us that they "hadn't got around to reading them."

●We saw people's care and support plans were not reviewed to account for any personal or health changes and in places contained contradictory information. For example, one person required support with their medicines. Their care and support plans stated that they could make decisions regarding this but the assessment said that they couldn't. These plans did not give definitive information to staff on how to best support people.

●People did not have information presented in a way that they found accessible and in a format, that they could easily comprehend. Neither the registered manager or provider were aware of the Accessible Information Standards. The Accessible Information Standards sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss. One person had been identified as short sighted. The registered manager told us that they did not wear their prescribed glasses. However, the registered manager confirmed with us that they had not done anything to help the person get used to the glasses or encourage them to wear them. There was no plan to support the person with their reduced vision as part of their care planning.

• People took part in activities that they enjoyed, found interesting and stimulating. The activities that people took part in were based on their individual preferences and likes.

Improving care quality in response to complaints or concerns

● The provider had systems in place to respond to complaints.

End of life care and support

● At this inspection no one was receiving end of life care. Should someone require end of life care then the

registered manager and the provider would work with the placing authority to see if they were able to meet such needs.

Inadequate

Is the service well-led?

Our findings

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

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Leadership and management

Managers and staff are clear about their roles, and understand quality performance, risks and regulatory requirements.
• A registered manager was in post and was present on day two of this inspection. The registered manager and provider had not appropriately submitted notifications to the Care Quality Commission. The provider is legally obliged to send us notifications of incidents, events or changes that happen to the service within a required timescale. At this inspection we identified four events which should have resulted in a notification to the Care Quality Commission but which had not been completed. We asked the registered manager about these. They told us they didn't realise that they had to make such a notification.

This was a breach of Regulation 18: Notification of other incidents (Registration) Regulations 2009: Regulation 18.

• The registered manager and provider failed to display the rating of the service as required to do so by law. We asked the registered manager about this. They told us they didn't know about this requirement and so hadn't displayed it.

This was a breach of Regulation 20a: Requirement to display, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider and registered manager failed to complete the provider information return. We asked the provider and registered manager about this and they could not provide an explanation why this had not been completed.

Continuous learning and improving care
• The registered manager failed to keep themselves up to date with current practice and changes in the law which informed their work with people. For example, the registered manager did not know about or implement the Accessible Information Standards. The registered manager failed to update their understanding regarding the completion of mental capacity assessments after this was previously questioned with them by a visiting professional. Instead they told us that they "Just stopped doing them."
• The registered manager told us that they did not undertake any professional development training, courses or activities which expands on their learning. They told us that they have completed the essential refresher training for example, first aid, but they did not routinely keep themselves up to date with changes

in health and social care. We asked about updates from organisations involved in adult care and the registered manager told us that they do not subscribe to any form of professional update.

Provider plans and promotes person-centred, high-quality care and support, and understands and acts on duty of candour responsibility when things go wrong
• The provider had a quality monitoring check in place. However, one staff member told us that this had been delegated to the administrator. We looked at these checks and there had only been two completed throughout the year 2018 and neither had been completed by the provider. These checks failed to identify the issues that we found at this inspection. The provider and registered manager did not have effective quality monitoring systems in place to drive improvements.
• Neither the provider or registered manager had plans in place to improve the care experience for those living at Phoenix House.

Engaging and involving people using the service, the public and staff
• People told us, and we saw, that they were asked for their views on the service that they received. A recent service user survey had been completed but results had not been shared with people or relatives at the time of this inspection.
• Relatives we spoke with told us they do not recall ever receiving a survey or being asked for their opinion on the service that their family member received.

These issues constitute a breach of Regulation 17: Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others
• The management team had established and maintained good links with the local community and with other healthcare professionals.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had not made the notifications that they were required to do.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider was not displaying their last rated inspection as required.

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 17 HSCA RA Regulations 2014 Good governance The provider and registered manager had ineffective quality monitoring processes in place and had not kept themselves up to date with current practice.

The enforcement action we took:

We issued the provider with a warning notice.