Linkage Community Trust

The Phoenix

Inspection report

St. Helens Avenue
Lincoln
LN6 7RA

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16 August 2022
18 August 2022

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Phoenix is a residential care home providing personal care to up to maximum of six people. The service provides support to people living with learning disabilities and autism. At the time of our inspection there were six people using the service.

People's experience of using this service and what we found

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right support
People were not always supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests.

Care records we reviewed stated people living at the service did not always feel safe, due to other people being distressed. Incidents and accidents were not always effectively recorded. There were inconsistencies in people's care records when incidents had occurred, making the monitoring and management oversight of incidents ineffective. Senior management were developing systems to improve this process. Since the inspection these new processes have been implemented.

Risks associated with people's care needs were not always identified and acted on in a timely manner. Risk assessments and care records were not always updated effectively. The management team had identified issues with risk assessments prior to the inspection and were working on an action plan.

People's medicines were not managed safely in line with national guidance. Medicine administration records (MARs) did not always give staff the information needed regarding the route in which medicines should be administered. Information on how people would like to receive their medicines was not detailed or personalised. The management team said that they would act on our findings and changes would be made to the MARs on the next medicine's cycle, this would be achieved with support from the GP and pharmacy.

Areas of the home needed maintenance. An outside decking area needed repair which mean people could not use the outside space. Cleaning schedules had not been completed by staff. Areas of the home required cleaning. Staff did not always wear face masks in accordance with government guidance.

Right Care

People's care records did not always promote their care being delivered in a person-centred way. There were improvements needed to the language used in people's care records to ensure they were treated with respect and dignity.

People's care records did not always reflect their needs and wishes. The management team had identified issues with care plans prior to the inspection and were working on an action plan.

We observed staff interacting with people in a kind and caring manor.

Right Culture
The COVID 19 pandemic had a negative impact on staffing and the provider continued to work to address this. They had worked to restructure the service to ensure people were supported by staff who knew and understood them well. They were responsive, supporting people's aspirations to live a quality life of their choosing.

Although there had been many anonymous whistle blowers about the service. Concerns were investigated by the provider and their quality monitoring team.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 01 January 2020)

Why we inspected
We undertook this inspection to assess that the service is applying the principles of Right support Right care Right culture. The inspection was prompted in part due to concerns received about allegations of abuse, staffing and management culture. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of Safe, Effective and Well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Phoenix on our website at www.cqc.org.uk

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took

account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, deployment of staff, how the service gains consent when people do not have capacity to make decisions, ensuring DoLs applications are applied for and good governance at this inspection.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

The Phoenix

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by one inspector

Service and service type
The Phoenix is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. The Phoenix is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with one person about their experience of using the service and three relatives. Not all of the people living at the service were able to communicate their views and experience of living at the service. We spoke with six staff members including support workers, deputy manager, operations manager and nominated individual to discuss their experience of working at The Phoenix. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records. Including six people's care records, medicine records and two staff files. We saw a variety of records relating to the management of the service, including policies and procedures, audits and staff training.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- Risks associated with service users care and support were not always identified, assessed or mitigated.
- One person at the service who was assessed as not being able to keep themselves safe alone in the local area, had left the service unsupervised on two occasions. However, not all doors were alarmed. This posed a risk that people could leave the service unsupervised without staff knowledge.
- Another person living at the service required the use of oxygen. A risk assessment was in place. However, it did not give the staff all the guidance needed to be aware of all risks associated with the use of oxygen.

Using medicines safely

- Medicines were not managed safely at the service.
- Medicines records did not always contain all the necessary information required for safe practices. One person had a Percutaneous endoscopic gastrostomy (PEG) in situ and required their medicines to be administered via the PEG. However, this was not documented on their medical administration records (MAR) Although staff knew the person well and did administer medicines via their PEG the lack of guidance posed a risk that the medicines would not be administered in the correct way. A PEG is a tube inserted directly into the stomach to allow foods, fluids and medicines to pass directly into the digestive tract.
- Some of the medicines administered at the service required two staff to administer and sign the record. However, records showed these medicines had been administered by one person. This showed staff were not working in line with the provider's medicines policy. Second signatures were frequently missing. This posed a risk that medicine errors would not be identified.
- One person at the service was prescribed a medicine to help them manage their stress. The medicine was prescribed as and when needed. (PRN) Although there was a PRN protocol on place, the protocol did not give staff the guidance needed regarding when they should administer the medicine. This had led to inconsistent staff practice, which posed a risk that the person could suffer unnecessary distress.

Preventing and controlling infection

- There were several areas of the service where maintenance was required to ensure hygienic cleaning would be effective. For example, radiator covers in bathrooms were damaged. The laundry room was in a converted garage. However there had been no changes made to the flooring to reduce the risk of infection.
- The provider and registered manager had not ensured that hygienic cleaning practices were taking place. Cleaning records we reviewed were not always completed and areas of the home looked visibly dirty.
- Staff did not always were their PPE such as masks in accordance with government guidance.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

● People at the service did not always feel safe. There were times when people at the service experienced distress. Staff had documented in incident records that people had retreated to their bedrooms as they were scared.
● Accidents and incidents were not always recorded effectively at the service. Incident records and daily records that we reviewed, showed that not all incidents were reported to the management at the service. This meant that lessons could not be learnt following an incident.

The provider failed to identify and mitigate risks in order to keep people safe. This is a breach of Regulation 12 (safe care and treatment) of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider acted during the inspection to ensure actions were taken to improve medicines management. Some issues referred to in this key question were identified by the provider's quality team prior to the inspection. An action plan was put in place in order to make improvements.

● Staff had received training around their responsibilities to report safeguarding concerns.
● There were safe recruitment processes in place at the service.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

We have also signposted the provider to resources to develop their approach.

Visiting in care homes
● People and their families were encouraged and supported to visit at the service.

Staffing and recruitment
● There were not always enough staff deployed at night to ensure risk assessments and management plans could be followed. At the time of our inspection there was one staff member deployed on night shifts with an on-call system for support. We observed there to be enough staff deployed during the day, but changes had not been made to shift patterns or numbers at night times, when people's needs had changed.
● Two of the people at the service had complex needs, one person's needs were medical, another person needed support when they became distressed. With only one member of staff on during the night there was a risk that the staff member would not always be able to meet the needs of all the people living at the service.
● Records showed staff were supporting a person who was distressed during the night-time hours. Although there was a buddy system where a staff member form a sister service would call every 2 hours and an on call system in place, there was still a risk the night staff member would not be able to alert the on-call or buddy worker if for example, they had been assaulted or were unable to leave the person they were supporting.
● One person's relative told us they were concerned a lone night staff member would not always be able to meet the needs of the people living at the service. They were concerned that health care needs would not always be monitored, and that the lone worker would not be able to alert an on-call worker when needed if they were supporting a person at a crucial time.
● Staff told us, day staff were supporting people with their night time routine as the lone night worker would not be able to meet the needs of all people at the service.

The provider had failed to ensure there were always enough staff deployed to meet the needs of people. This is a breach of Regulation 18 (Staffing) of Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

The provider said they would discuss contractual agreements with the local authority, as well as looking into different options in order to ensure staff would be deployed to meet the needs of all people.

Requires Improvement

Is the service effective?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires Improvement. This meant 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
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 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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- There was a lack of understanding by staff and the management team regarding MCA and DoLS.
- The registered manager and deputy manager had not identified that some people living at the service required a DoLS authorisation to be in place. This placed people at risk of being unlawfully deprived of their liberty.
- There was only one person who did not require a DoLS in place. However, out of the other six people there was only one person who had an up to date DoLS authorisation. One person had been living at the service for other a year. A DoLS authorisation had only been applied for once they had left the service without supervision.

The provider did not always identify and assess people in order to apply for a DOLS authorisation, this is a breach of Regulation 13 (5) Safeguarding (DoLS) of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Staff did not always act in the least restrictive way possible. For example, due to a person leaving the service unsupervised. Staff had locked the main door. The deputy manager informed us that the staff had done this without guidance from the management team, in order to keep [Person] safe. Both the operations

manager and the deputy manager said they would address this with the staff as the door should not be locked during the day, as the service does not have a locked door policy.
● People's views or need for someone to advocate for them was not always considered prior to the management team progressing with decisions about the person.
● During the inspection process we were alerted to plans in relation to decisions being made by the provider regarding one of the people at the service. The provider had not followed the principles of the Mental Capacity Act and had not involved family and key workers in this process.
● We discussed this with the quality manager and nominated individual who, following an investigation, recognised processes had not been followed. They have assured us they will be working with the family and persons key worker.

People were not always supported within the principals of the mental capacity act this is a breach of Regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's care records and risk assessments were not always up to date or reflective of their needs. This meant it was not always clear if assessments reflected people's current needs and choices.
● The service supported people to communicate in their own individual ways using a range of communication tools. However, care records did not always reflect this. For example, one person's first language was not English, this was not clear in their care records. There was no reference in the person's care records regarding their cultural identity.
● Many of the staff working at the service also worked at other Linkage sites. The other sites supported people who were in community supported living. Not all the staff understood the difference between community supportive living and residential care. This had led to misunderstandings around DOLS.
● Staff told us they had received a thorough induction period, where they had shadowed more experienced staff. However, most of these shadow shifts had been at other sites run by the provider, all of which were community supported living placements, rather than residential like The Phoenix.

Staff support: induction, training, skills and experience
● Staff had received the relevant training or refresher training in order to meet the needs of the people at the service.
● Staff told us they felt their induction period was very well organised, giving them enough skills and knowledge to start supporting people.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff worked with outside agencies to support people with their mental health and to support staff to understand how to manage when people became distressed. However, the outcomes of this work were not effectively documented to allow staff to refer to any guidance given.
● Staff had been working with a specialist in managing who showed signs of distress. They were working towards a positive behavioural plan. However, despite having worked with the person and staff for several months, the person's care records had not been updated to reflect this work at the time of the inspection.
● Staff supported people to attend medical appointments. However, one family member told us the outcome of these appointments was not always shared with them.
● Staff supported and encouraged people to access the community, going to local parks and shops as well as a day centre run by the organisation. During the inspection we observed positive engagement between people and the staff that were supporting them. The service was busy with people come and going from

their home into the community.

Adapting service, design, decoration to meet people's needs

● The service was an adapted family home. The deputy manager told us that the provider had made several alterations prior to people moving in to make the best use of the space available. However, maintenance at the service had not always been completed. For example, there was only a small outside space available for people to access. This space had decking fitted which was damaged, making the space unsafe for people to use.

● People were able to choose how to decorate their bedrooms. However, one family member told us there had been issues with the service getting someone to put together furniture. The family did this for their loved one to prevent any further delay.

Supporting people to eat and drink enough to maintain a balanced diet

● Staff supported people to make independent choices about their food. Where possible people were encouraged to be involved in the preparation of their meals.

● Staff were aware of the nutritional needs of the individual people at the service. One staff member told us, "We promote independence. We watch [person] when they are eating as they can eat too fast."

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Governance systems were not always effective. This meant there were many shortfalls in service provision which the provider had either failed to identify and/or address, increasing risks to people's safety and well-being. For example, care plans had been reviewed by staff. However, these reviews did not identify some of the issues found during inspection such as not being person centred and up to date.
- Swift action was not always taken to address known issues. The providers quality team had conducted a review of the service six weeks prior to our inspection. Despite some high risk deficiencies being found, there had been no action taken following this audit as the operations manager and registered manager had been on leave.
- The quality review audit had identified medicines were not frequently counter signed by staff; and that positive behaviour support plans (PBS) needed to be in place. However, even though work had been undertaken around PBS, this was not documented. Failure to take timely action exposed people to the risk of unsafe support that did not meet their needs.
- The provider had failed to ensure national legislation was followed. Mental capacity assessments were not always in place as required and DoLS applications had not been made for service users who were being deprived of their liberty.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Care records did not always reflect practices seen in an open culture. Improvement was needed in quality of records and the language used in care plans.
- Language used in care plans was not always objective and did not always promote dignity and respect. For example, one person's care records referred to them being 'disruptive' or 'in a bad mood'. This had not been identified in provider audits and consequently had not been addressed

Continuous learning and improving care

- Systems and processes for reporting and recording incidents were not effective. Not all incidents were recorded on the incident log and where they were recorded, there was insufficient detail to enable the identification of themes and trends.
- Although we had been told of incidents where a person had left the service without supervision, we could not find an incident form that related to these incidents. This put the person at further risk and did not identify why they might be trying to leave without support.

The provider's failure to effectively monitor the quality and safety of the service was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Due to several changes in the management team staff were not always aware of who was currently running the service.
- Staff had received recent supervision. However, the deputy manager informed us that prior to supervisions undertaken in June 2022 supervisions had not taken place regularly in the past.
- The senior management team said they were working on how to better involve and gain the views of people at the service.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Working in partnership with others

- Families told us that communication was not always effective and they were not always told when incidents happened in the service that effected their loved one. The nominated individual and operations manager said the service would work on improving relationships with families.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People and their advocates were nto always involved in decisions about their care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Applications had not always been made for DoLs as required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was not an effective amount of staffing deployed at night in order to meet the needs of all the people at the service

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to identify and act on all risks associated with peoples care.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure the effective oversight of the service and to make improvements in a timely manor.

The enforcement action we took:

Warning notice