Phoenix Cottages Ltd

Phoenix Lodge

Inspection report

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High Peak
Derbyshire
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Tel: 01663749257

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Phoenix Lodge is registered to provide accommodation and personal or nursing care for up to 16 people with a learning disability and/or autism across three dedicated houses. At the time of the inspection there were 16 people receiving care at the service.

People's experience of using the service and what we found
The provider did not fully ensure effective governance and oversight of the service for the quality and safety of people's care and timely service improvement when needed.

Arrangements for staffing and risk management strategies to monitor, report and analyse people's safety were not always sufficient to consistently ensure people achieved the best outcomes.

Staff knew how to recognise and report abuse but were not always confident to do so. When things had gone wrong, the incident reporting and review process did not always identify how to prevent the same thing happening again.

Staff generally understood people's care needs, individual characteristics and daily living preferences, which they followed. People's related care plans and their needs assessments were not always accurately maintained to fully inform people's care. Some improvements actions were in progress to help rectify this.

The provider's arrangements for people's medicines and prevention and control of infection at the service helped to ensure people's safety.

People were generally happy living at the service and relatives felt people were safe and comfortable there. Staff, people and relatives were often engaged and consulted to help inform or improve people's care.

The provider worked in partnership with relevant authorities and external care professionals to help enhance and inform people's care, independence and equipment needs.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, 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 providing support to people with a learning disability and/or autistic people.

The service was able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture. People had choice, control and independence and their privacy, dignity and human rights were promoted.

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 March 2019)

Why we inspected
We received concerns relating to people's safety. This included staffing, safeguarding, risk management and incident reporting practices within the service. As a result, we carried out a focused inspection to review the key questions of safe and well-led only. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection. You can see what action we have asked the provider to take at the end of this full report.

We have identified a breach of Regulation in relation to governance at this inspection.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well led.

Details are in our Well Led findings below.

Phoenix Lodge

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, 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 team consisted of two inspectors, an assistant inspector, a specialist advisor in health and learning disabilities and an expert by experience. An expert by experience is someone who has experience of care related to this inspection setting.

Service and Service Type
Phoenix Lodge is a registered care home. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, both were looked at during this inspection.

There was a manager registered with the Care Quality Commission. A registered manager and provider are legally responsible for how the service is run and for the quality and safety of the care provided. However, shortly before this inspection the registered manager had moved into a senior external management role for the provider and a new manager was recently appointed at the service, not yet registered. Throughout this report they will be referred to as 'the manager'.

Notice of inspection
This inspection was unannounced. However, we did announce our arrival before entering the premises because we needed to check the current Covid-19 status for people and staff in the service and we wanted to be sure there would be people at home to speak with us.

What we did
We looked at information we held about the service to help us plan the inspection. This included written

notifications the provider had sent to us about any important events that happened at the service. We contacted local care commissioners who contract for people's care and spoke with five social workers. On this occasion we did not ask for a Provider Information Return. This is information we ask the provider to send us; to give some key information about the service, what the service does well and any improvements they plan to make. However, we gave the manager and provider opportunity to provide us with related information to help inform our inspection.

During this inspection
We spoke with four people receiving care at the service and 10 care staff, including three team leaders. We also spoke with the manager, an external senior manager and the nominated individual for the provider. We reviewed seven people's care records and checked a range of records relating to the management and operation of the service. This included staffing, medicines, incident reports and areas of care policy. We also looked at the provider and management checks on the quality and safety of people's care.

After the inspection
We continued to seek clarification from the provider to validate evidence found. This included staffing, risk management and quality assurance information.

Requires Improvement

Is the service safe?

Our findings

At our last inspection the service was rated as good. At this inspection, the service had deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There as an increased risk people could be harmed.

Systems and processes to safeguard people from harm or abuse

- The provider had not always told the local safeguarding authority about incidents as soon as they happened at the service. This meant there had not always been an independent review of incidents in a timely manner.
- The provider had recognised the error in not referring an incident to the local safeguarding team and had since worked in consultation with them, to help review and ensure people's safety at the service. Following this inspection, we have received three further notifications from the provider regarding further safety incidents relating to one person's care. These are currently under review.
- Staff understood how to recognise and respond to suspected or witnessed abuse. However, staff were not always confident to raise concerns for fear of reprisal or blame. The provider's whistleblowing policy did not effectively inform or support staff. It did not fully adhere to recognised national guidance for whistle blowing in the workplace, therefore did not promote an open culture for people or staff.

Staffing and recruitment

- There were not always enough staff to fully ensure people's safety or for people to receive the level of support commissioned for them. Staff felt there was not always enough staff or sufficient break times, to enable them to consistently support people in a safe, timely manner.
- Safe staff recruitment procedures were followed. This included required pre-employment checks to ensure prospective staff were safe and suitable to work provide people's care, as vulnerable adults.

Assessing risk, safety monitoring and management

- Risks to people's safety were usually assessed in a timely manner, and staff were often guided how to support people safely. However, this was not always completed consistently. People's care plans did not always inform staff of their care and safety needs. This included when new people moved in to the service as their compatibility with the people already living there was not explored.
- The environment was variable in terms of the standard of décor and maintenance. Measures and repairs for people's safety were not always completed in a timely manner. This included some areas for repair, which had not been completed despite being identified through the provider's own safety checks.
- People were generally happy living at the service. People's relatives felt they were safe and comfortable there. However, some relatives felt repairs and redecoration needed to be completed in a more timely manner.

Learning lessons when things go wrong

- When things had gone wrong, the provider did not always complete a thorough review with all relevant people to ensure they could reduce the risk of the same thing happening again . When staff had recorded safety incidents, related management reviews showed there were often missed opportunities to recognise

improvements that could made, to prevent any reoccurrence.
● Following incidents where people had become distressed and at risk of harm, the management team did not always support staff through formal debriefs. This meant there was a missed opportunity to reflect and consider what could be done differently in the future.

Safe use of medicines
● People's medicines were safely managed and given. People received their medicines when they should.
● Where people were prescribed medicines for as and when required, such as for pain relief or for severe agitation, written protocols were in place for staff to follow, to help ensure these medicines were given consistently and safely when needed.
● People were supported to safely take their medicines. Staff responsible for people's medicines were trained, knowledgeable and had their competency checked, to ensure safe practice.
● Relatives felt there were safe arrangements for people's medicines. One relative said, "Yes, I do think it's safe. They didn't have rescue medicines in place for [Name] at first; but they have sorted that now."

Preventing and controlling infection
● We were assured the provider had effective measures for infection prevention and control (IPC) at the service, to protect people from the risk of a health acquired infection through cross contamination.

● We were assured the provider was admitting people safely to the service; preventing visitors from catching and spreading infection and meeting with shielding and social distancing rules.
● We were assured the provider was using personal protective equipment effectively and safely. They were mostly promoting safety through the layout and hygiene practices at the premises, but the safe, hygienic storage of cleaning mops was not ensured. We discussed this with the manager who agreed to take the required action, to rectify this to ensure safety.
● People were supported to understand how to keep safe in relation to Covid 19; and also to participate in helping to maintain cleanliness and hygiene at the home. One person's relative said, "The house [Name] lives in is always clean and spotless and visiting has been safely arranged during Covid." Another relative told us, "[Name] is very proud of their mask and knows about using the sanitisers. They definitely understood what staff told them; and enough for them to make sure that we sat on the chairs placed apart and didn't move too close to them during a visit."

Requires Improvement

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- A range of management audits and incident reviews were completed, to help check the quality and safety of people's care. However, provider oversight and analysis of these was not always sufficient to ensure people consistently received safe, effective care. Some of the examples we found included insufficient or inconsistent staffing arrangements; behavioural incidence reporting, analysis and review; and environmental safety measures.
- We saw repeated examples where provider reviews of individual safety incident records had concluded that no care review or changes were needed. However, this was often contrary to the actual information staff had recorded, which meant there were missed learning opportunities to inform and improve people's care. This included to help reduce individual's repeated safety incidents and the use of future restraint.
- The provider's whistle blowing policy did not effectively promote the principles of openness, fairness and transparency, including staff's rights in relation to any safety concerns they may raise, and for their protection and support. Staff were not always confident to raise any safety concerns they may have relating to people's care, for fear of reprisal. Other policies we reviewed did not always evidence or reference relevant nationally recognised guidance. This meant we could not be fully assured of safe, effective practice at the service.
- When people moved into the service, there was an assessment of their individual needs and preferences. However, there was no evidence of any communication with people already living there or consideration of how they may be affected. For example, in relation to known behaviours associated with a person's mental health, which meant they could be challenging towards others they lived with.
- The provider's own full home audit report of August 2020 identified a range of improvements needed to ensure the service was fully safe and well led. This included some of the areas of improvement we identified at this inspection. However, their related action plan dated October 2020 did not fully assure action or timescales for improvements needed, including who would be responsible.

The provider's governance framework was not always effective to consistently ensure the quality and safety of people's care, or to ensure pro-active, timely service improvement when needed. This meant there was an increased risk of harm. This 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

● People, relatives and staff were often engaged and involved in a way that ensured their rights were respected and promoted.

● Staff felt they were often engaged and consulted in a way that helped to inform and support them to provide people's care. This included through staff group and individual supervision and support meetings.

● There was evidence that relatives and people were involved in their individual care planning. Relatives told us they were also asked for their views via the provider's periodic care quality survey questionnaires.

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

● The interactions we observed between people and staff were often person-focused. Overall, staff demonstrated a good understanding of people's personal care needs, daily living preferences and individual characteristics.

● Feedback from people and their relatives was that they were generally happy with the care provided at Phoenix Lodge and were confident staff knew people well and had close, caring and supportive relationships with them. We saw many examples of this during the inspection.

Working partnership with others

● The provider worked in partnership with relevant authorities and external health and social care professionals to help inform and agree people's care.

● Relationships were established with relevant external health professionals to help inform people's long-term health needs. People's care plans showed when referrals were made to relevant external health professionals and any related care instructions, which staff understood and followed. This included for the provision of bespoke equipment when needed. Examples we found included obtaining a weighted blanket for one person to help them feel safe and provision of 'prompt' dining placemat for another person, to help them eat and drink safely.

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

● Management and staff we spoke with understood the principles of the duty of candour and what this meant for peoples' care.

● The provider was working in consultation with local authority safeguarding and commissioning teams, to make agreed care planning improvements for with people's care and safety at the service.

● Relatives felt they were kept informed about people's care and any related concerns. One relative said, "Communication is very good; they let me know when important things happen."

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 17 HSCA RA Regulations 2014 Good governance The provider's governance framework was not always effective to consistently ensure the quality and safety of people's care, or to ensure pro-active, timely service improvement when needed. This meant there was an increased risk of harm.