Total Care Homes Limited

Phoenix House Care Home

Inspection report

54 Andrews Lane
Formby
Merseyside
L37 2EW
Tel: 01704 831866

Date of inspection visit: 25 & 26 February 2015
Date of publication: 08/06/2015

Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Overall summary

Phoenix House is located in a residential area of Formby. The home provides accommodation and support for up to 30 people. The majority of people who currently lived at the home had some degree of memory loss.

There is disabled access and car parking. Communal areas include two lounges, a dining room and an enclosed back garden. There is no lift access on the second floor of the home therefore people accommodated on this floor need to be mobile as they are required to use the stairs. Nursing care is provided by a district nurse service when required.

This was an unannounced inspection which took place over two days on 25 and 26 February 2015. The inspection team consisted of an adult social care inspector, a CQC (Care Quality Commission) pharmacy inspector and a specialist advisor. This is a person who has experience and expertise in health and social care and for this inspection we had a specialist advisor who had a background in mental health. The specialist advisor attended the home on the first day of the inspection.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered

Summary of findings

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 followed up on a previous inspection of 21 and 22 October 2014 where there had been a breach of the regulation regarding the safe administration of medicines. As a result of our findings during the inspection in October 2014 a compliance action was issued to the provider requiring them to take swift action to make improvements to the way medicines were managed at Phoenix House. The provider sent us an action plan which showed us the actions they were taking to ensure people medicines were being managed safely.

On this inspection we found we found that people living at the home were still not always protected against the risks associated with the use and management of medicines. People did not always receive their medicines at the times they needed them or in a safe way. We looked at the systems in place for managing medicines in the home. This included the storage and handling of medicines as well as a sample of Medication Administration Records (MARs), stock and other records for ten people living in the home. Overall, we found that appropriate arrangements for the safe handling of medicines were not in place.

A number of people living at the home had needs associated with memory loss so were unable to verbally share with us whether they felt safe in the way they were supported by staff. For this reason we spent periods of time throughout the inspection observing how staff supported people. Our observations showed people felt as ease with the staff and there was a good rapport.

We found staff levels were satisfactory at this inspection. Staff attended to people's needs in a timely manner. No one was left waiting for assistance.

We looked at how staff were recruited. We looked at staff files and appropriate applications, references and necessary checks that had been carried out to ensure staff employed were suitable to work with vulnerable people. The necessary checks were in place to evidence this.

We spoke with the staff about abuse. Staff told us what abuse was and gave good examples to illustrate this. Staff knew the correct procedure to follow if they thought someone was being abused. Training records confirmed staff had undertaken safeguarding training.

We found the home were managing risks to people. For example risks associated with poor mobility, falls and nutrition. We saw the use of bed rails to minimise the risk of people falling out of bed and the use of sensors to alert staff when a person (who was at risk of falls) had got out of bed unaided. Where an increase in risk had been identified, measures had been put in place to help keep people safe.

The provider undertook safety checks of the environment to ensure it was safe and this was reported through their monthly audit (check) which we saw. General repair work was reported in the diary and actioned.

The provider and manager have actively sought guidance on and researched ways in which the lives of those suffering from dementia could be enhanced and their abilities maximised. This included changes to the home's environment, coloured crockery for easy recognition and framed posters as a memory aid.

We found the home to be clean and tidy. Gloves and aprons were available for staff use when giving care and food preparation.

During our inspection we observed staff providing support to people in accordance with individual need. On the whole staff communicated well with people they supported. Over one lunch time however we observed minimal interaction by the staff when assisting people with their meals. Staff did not talk to people about their meals or engage in day to day chat, which is an important part of people's social care. We brought this to the attention of the provider. During other times staff communication and interaction was good.

We talked with staff about a number of people's care needs. Staff had a good knowledge of people's individual needs and how they wished to be cared for.

We reviewed the care and support for five people who were living at the home. People had access to external health professionals and referrals and appointments had been made at the appropriate time. A person told us "I can see my doctor when I want, it's not a problem."

Summary of findings

Staff received on-going training and support to ensure they had the skills and knowledge to meet people's needs. Staff we spoke with confirmed they undertook training. A number of staff had a qualification in care, such as NVQ (National Vocational Qualification) or Diploma, which demonstrated a commitment to formal learning in care.

The service was working within the legal framework of the Mental Capacity Act (MCA) (2005) and also Deprivation of Liberty Safeguards (DoLS). The MCA provides a statutory framework to empower and protect vulnerable people who are not able to make their own decisions. In situations where the act should be and is not implemented then people are denied their rights to which they are legally entitled. DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests.

People living at Phoenix House Care home varied in their capacity to make decisions regarding their care. The provider informed us a number of 'best interest' meetings had been held. We looked at these records and found them to be completed and compliant with the requirements of the MCA.

In one case, there was no evidence that a mental capacity assessment had been carried out to determine whether the person had the capacity to understand the implications of refusing their medication. This was brought to the provider's attention.

Although care staff did not have a theoretical knowledge of the MCA legislation they appeared to be integrating the principles of the MCA into their practice, which helped to transform the experience of adults with care and support needs. For example, assisting people to make a choice, giving them time and assisting them with their decision making when necessary.

Staff told us by talking with people they obtained their consent to assisting them with daily activities and care. Relatives told us they were consulted regarding decisions about their family member's care.

People told us the staff were polite and spoke with them in respectful manner. Staff told us ways in which they protected the dignity and privacy of people, particularly in relation to the provision of personal care. For example, always ensuring bedroom doors were closed when providing personal care. Relatives told us the staff were very caring and kind at all times and there were no restrictions on when they could visit. Their comments about the staff included, "Always kind and helpful" and "You could not have more kindness."

Staff discussed with us how they encouraged people to be independent. People had the use of walking aids and we observed staff encouraging them to use these to help promote their independence.

People had a plan of care athough not all the care plans contained a level of information that would guide staff in providing personalised care. The manager advised us they were undertaking reviews of the care documentation to ensure it recorded information tailored to individual need; thus making them more person centred. Staff we spoke with were knowledgeable regarding people's care.

We saw that people were offered a variety of activities that were thought out, stimulating, enjoyable and appropriate for the needs of those living with dementia. During the inspection the activity was a singer with guitar, who sang mostly 1950's songs. People and their relatives joined in and this was very lively and enjoyable.

We observed a complaints procedure was in place and people we spoke with and relatives were aware of how to raise a complaint. We saw that any concerns or complaints made had been addressed and a response made.

Systems were in place to monitor the quality of the service. The provider had carried out audits to determine how well medicines were handled. These checks however, had failed to spot many of the concerns and discrepancies that we found during our visit. This meant there was not a robust system of audit in place in order to identify concerns and make the improvements necessary to ensure medicines are handled safely within the home.

People who lived at the home and relatives were given satisfaction questionnaires to provide feedback about the service provided.

Staff informed us the management of the home was open and transparent. Staff told us they were supported by the

Summary of findings

manager and provider and they would be confident in speaking to them if they had a concern. Staff we spoke with were aware of the home's whistle blowing policy and they said they would use it.

You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

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

We found that people living at the home the service were not always protected against the risks associated with the use and management of medicines.

We found the home were managing risks to people. Where an increase in risk had been identified measures had been put in place to help keep people safe. For example, people at risk of falls.

Staff understood what abuse meant and knew the correct procedure to follow if they thought someone was being abused.

There were enough staff on duty at all times to help ensure people were cared for in a safe manner.

Appropriate recruitment checks were in place to ensure staff were suitable to work with vulnerable people.

Is the service effective?

Good

The service was effective

The home worked in accordance with the principles of the Mental Capacity Act (2005) to support people who lacked capacity to make their own decisions.

People had access to external health care professionals and staff arranged appointments when they needed them.

People liked the menu and were offered plenty of choice. Their nutritional needs were monitored by the staff.

Staff received on-going training and support to ensure they had the skills and knowledge to meet people's needs

Is the service caring?

Good

The service was caring

Throughout the inspection staff spoke with people in a respectful manner. Staff were caring and discreet in their approach.

Staff told us ways in which they protected the dignity and privacy of people, particularly in relation to the provision of personal care. We observed people's dignity being upheld during our inspection.

People and their relatives were involved in making decisions about their care. Staff had a good knowledge about people's family life and what was important to them.

Summary of findings

Is the service responsive?

Good

The service was responsive

People had a plan of care. Not all care plans were sufficiently detailed to provide personalised care however staff were knowledgeable regarding people's care and current risks to their health.

People were able to make choices about their daily lives. We saw that people were offered a variety of activities that were thought out, stimulating, enjoyable and appropriate for the needs of those living with dementia.

Details of the service's complaints procedure was available in the home's service use guide. The complaints procedure along with a comments book was also readily visible and accessible in the entrance hall of the home for people to access.

Is the service well-led?

Requires Improvement

The service was not always well led

We found the provider did not have a robust system of audit in place in order to identify concerns and make the improvements necessary to ensure medicines were handled safely within the home.

Staff were positive regarding the overall management of the home and the leadership of the manager.

Staff we spoke with were aware of the home's whistle blowing policy and they said they would use it.

Phoenix House Care Home

Detailed findings

Background to this inspection

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

This was an unannounced inspection which took place over two days, 25 and 26 February 2015.

The inspection team consisted of an adult social care inspector, a CQC (Care Quality Commission) pharmacy inspector and a specialist advisor. This is a person who has experience and expertise in health and social care and for this inspection we had a specialist advisor who had a background in mental health. The specialist advisor attended the home on the first day of the inspection.

Prior to the inspection we reviewed the information we held about the organisation. We did not ask the provider to complete a Provider Information Return (PIR) before the inspection. The PIR 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. Prior to the inspection we looked at the notifications and other information the Care Quality Commission had received about the organisation.

As part of the inspection we spoke with four people living at the home. We spoke with the registered manager and five care staff. We spent time observing the care provided to people who were living at the home to help us understand their experiences of the service.

We looked at the care records for five people receiving care and support, four staff recruitment files, 10 medication records, policies and procedures and other records relevant to the quality monitoring of the service. These included safety audits and quality audits, including feedback from people who lived at the home, relatives and an external health care professional. We carried out a tour of the premises and this involved viewing communal areas, such as the lounges, dining room and bathrooms. We viewed a sample of bedrooms and also viewed the kitchen and laundry room.

We carried out a Short Observational Framework for Inspection (SOFI). SOFI is a methodology we use to support us in understanding the experiences of people who are unable to provide feedback due to their cognitive or communication needs.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 21 and 22 October 2014 we found the home in breach of the regulation relating to medicines. At that time the provider did not have appropriate arrangements in place to manage medicines. We found controlled medication was not recorded safely in accordance with the law, medicine administration charts (MARs) not being signed correctly and a lack of care documentation around supporting people with 'as required' (PRN) medicines. As a result of our findings during the inspection in October 2014 a compliance action was issued to the provider requiring them to take swift action to make improvements to the way medicines were managed at Phoenix House. The provider sent us an action plan which showed us the actions they were taking to ensure people medicines were being managed safely.

Overall, appropriate arrangements for the obtaining, recording, handling, using and safe administration of medicines were still not in place. People did not always receive their medicines at the times they needed them or in a safe way. People living at the home were therefore still not fully protected against the risks associated with the use and management of medicines.

We looked at the systems in place for managing medicines in the home. This included the storage and handling of medicines as well as a sample of Medication Administration Records (MARs), stock and other records for 10 people living in the home.

Most medicines in current use were kept securely in locked cupboards and trolleys. However, we found that medicines requiring refrigerated storage were not kept securely and in two examples named medicines were present in the fridge that were not listed on the people's corresponding MARs.

Most medicines could be accounted for as easily printed records were clear and accurate. However, we saw a small number of handwritten MARs where care workers had not accurately recorded the dose instructions and quantities of medicine received into the home (or carried forward from the previous month) This made it impossible to calculate the quantity of these medicines that should have been present and therefore determine whether or not the medicines had been given correctly. The health of people living in the home is placed at unnecessary risk of harm when medicines records are incomplete and/or inaccurate.

We looked at the arrangements in place for giving medication covertly (hidden in food) without the person's knowledge or consent. Administering medicines covertly is generally only necessary and appropriate in the case of people who actively refuse their medicines but who are judged not to have the capacity to understand the consequences of their refusal. In one case there was no evidence that a mental capacity assessment had been carried out to determine whether the person had the capacity to understand the implications of refusing their medication. The National Institute for Health & Care Excellence (NICE) require that a best interests meeting is held with the person's representative and relevant professionals to determine whether it is in the person's best interests for the medication to be administered covertly and which medicines this should apply to.

Mixing medicines in food and drink may alter the way in which the medicines work and may lead to them becoming ineffective or conversely, dangerous to use. This should be discussed with the pharmacist as part of the decision making process, but there was no record that this had been done. There was no information in place to tell staff exactly how and in what circumstances each person should have the medicines offered covertly. It was not always possible to see from records which medicines had been given covertly and which had been given with the person's knowledge and consent.

Many people living in the home were prescribed medicines to be taken only 'when required' e.g. painkillers and medicines for anxiety. We found that although some information was in place to guide care workers on how to give these medicines, for the majority of people this information did not contain enough detail to ensure that the medicines were given correctly and consistently with regard to the individual needs and preferences of each person. For example, one person had been prescribed lorazepam to help with their agitation, but there was no detailed information available to help care workers decide when to give this. Another person told us that they did not always get their pain relief tablets when they needed them. Failing to administer medicines safely and in a way that meets individual needs places the health and wellbeing of people living in the home at risk of harm.

The provider had carried out medication audits (checks), however these audits did not fully address all aspects of medicines management within the home.

Requires Improvement

Is the service safe?

As the provider did not have appropriate arrangements in place to manage medicines safely to fully protect people against the risks associated with medicines, this was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 12 2(f)(g)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A number of people living at the home had needs associated with memory loss so were unable to verbally share with us whether they felt safe in the way they were supported by staff. For this reason we spent periods of time throughout the inspection observing how staff supported people. Our observations showed people felt as ease with the staff and there was a good rapport. People who were able to share their views with us told us they liked living at the home. A person said, "I think it is a safe home for everyone to live." We spoke with three visiting relatives and they told us their family member was looked after safely by the staff.

We looked at staffing at the home. At our last inspection in October 2014 we found the home in breach of regulations relating to staffing. At that time the provider did not ensure there were sufficient numbers of qualified, skilled and experienced staff to support people during the evening and at night. We issued a compliance action and told the provider to take swift action. The provider sent us an action plan which showed us the actions they were taking to improve the staffing levels. They told us the staffing levels in the home were now satisfactory to meet the needs of the people accommodated.

At this inspection there were 20 people living at the home. We found the staffing levels had improved and there were sufficient numbers of staff on duty to provide care and support to people. An extra member of staff was now working between 6pm-10pm, as this had been identified as a busier time in the home where people required extra support.

We looked at the staffing rota for the month of February 2015 and this showed the numbers of staff; four care staff during the day and two care staff at night. The provider attended the home each day along with the manager whose hours were split between Phoenix House Care Home and Maryland Care Home, also owned by the provider. A member of the care team held the role of deputy manager and senior carers were appointed. The home did not employ a cook; the main meal of the day was prepared at Maryland Care Home and transported to the home. Laundry duties were undertaken by the care staff and a cleaner was employed Monday to Friday. A staff member told us the staffing levels were "Fine" at this time which enabled staff "To do things with residents, but then we do only have twenty residents at the moment."

The home was making adequate arrangements to ensure that staffing levels were sufficient to ensure that staff were not confined to only looking after people in a task centred way and that they could spend time with them supporting people with their individual needs.

The deputy manager was 'on call' outside of normal working hours along with the provider and manager should their assistance be required. These arrangements were confirmed by the care staff we spoke with. A member of the care team told us there was "Always someone on the end of the phone", should they need advice or support. A senior care told us "They (the provider) have enough staff to cover holidays and sickness and never have to use agency staff."

Staff were available to support people in accordance with their needs. For example, sitting with people on a 'one to one' basis, providing plenty of reassurance for people who had periods of agitation, answering calls for assistance and escorting people to the lounges and dining room for meals. Staff spent time in all three communal areas checking on people's comfort and safety. No one was left for long periods of time unobserved and call bells were answered promptly by the staff. A person told us, "The staff are always in and out of the rooms, checking things." Relatives we spoke with felt there were sufficient numbers of staff available to look after people.

We looked at how staff were recruited and the processes to ensure staff were suitable to work with vulnerable people. We saw four staff files for newly appointed staff. Appropriate checks were in place. This included an application form, two references and a Disclosure and Barring Service (DBS) check. This checks an applicant's police record and is an important to help ensure staff suitability. There was no record of the staff interviews conducted and the manager informed us they did not record this. This meant there was no record of the person's suitability for the position they were applying or any details around past training and what support they may need. The manager informed us this was discussed at the interview stage however they appreciated the need to record this for

Requires Improvement

Is the service safe?

future interviewees. They said this would be actioned. We spoke with a newly appointed member of staff who told us their past experience and training had been discussed during their interview and that they were now undertaking their induction.

We found the home were effectively managing risks to people. For example, risks associated with poor mobility, falls and nutrition. We saw the use of bed rails to minimise the risk of people falling out of bed and the use of sensors to alert staff when a person (who was at risk of falls) had got out of bed unaided. Where an increase in risk had been identified measures had been put in place to help keep people safe.

We spoke with the staff about abuse. Staff told us what abuse was and gave good examples to illustrate this. A member of staff said they understood how vulnerable people could be harmed and said, "I would not hesitate to report concerns to management." Training records confirmed staff had undertaken adult safeguarding training and were aware of appropriate channels to seek guidance\ assistance if they identified any safeguarding issues.

The provider undertook safety checks of the environment to ensure it was safe and this was reported through their monthly audit (check) which we saw. General repair work was reported in the diary and actioned. We found the home to be well lit and corridors were clutter free.

Personal evacuation plans (PEEPS) in the event of a fire were available for people and updated as required.

Records were kept of safeguarded incidents. Actions taken had been recorded and lessons learnt shared with staff. We saw that the contact numbers for the Local Authority adult safeguarding team were available.

We found the home to be clean and tidy. Gloves and aprons were available for staff use when giving care and food preparation. Cleaning schedules were up to date. A person living at the home told us, "The home is always spotless." The dining room had marks on the walls and the provider had responded by installing professionally purchased plastic wall panels which were easily cleaned. This helped to ensure the entrance area to this room was fresh and hygienic.

Good

Is the service effective?

Our findings

We observed staff providing support to people in accordance with individual need. On the whole, staff communicated well with people they supported whilst assisting them with care. We talked with staff about a number of people's care needs. Staff had a good knowledge of people's individual needs and how they wished to be cared for.

We looked at the care received by five people living at the home. The care file we looked at showed the number and variety of external health professionals involved with people's care. For example, district nurse team, doctors, chiropodist, dietician, ophthalmic professionals, community psychiatric nurse, and swallowing and language therapist. Referrals and appointments had been made at the appropriate time. Specific care plans were linked with medical conditions and also where medication had been prescribed, for example, people suffering with an infection. This meant the service was ensuring that people's health was at the forefront of their care and there were links with professionals to support this. An external health care professional told us the staff were prompt in seeking advice and support. This was confirmed by a relative we spoke with. A person told us "I can see my doctor when I want, it's not a problem."

Staff received on-going training and support to ensure they had the skills and knowledge to meet people's needs. Staff we spoke with confirmed they undertook e-learning training and also a practical training session for moving and handling. The manager supplied a copy of the staff training matrix which provided details of the training undertaken by the staff. This covered subjects including, moving and handling, health and safety, medication, first aid at work, safeguarding, infection control, fire awareness, dementia and managing aggressive violent behaviour.

New staff received an induction and worked a number of supernumerary shifts alongside more experienced staff. We observed this during our inspection.

Staff told us they had appraisals and supervision sessions and we saw dates of when these were conducted. The most recent staff meeting was held in December 2014 to introduce the new manager.

A number of staff had attained an NQV (National Vocational Qualification) or Diploma in Care. Seventeen care staff were working at the home and seven were enrolled or had an NVQ in Care. This demonstrated a commitment to formal learning in care.

We looked to see if the service was working within the legal framework of the Mental Capacity Act (MCA) (2005) This provides a statutory framework to empower and protect vulnerable people who are not able to make their own decisions. In situations where the act should be and is not implemented then people are denied their rights to which they are legally entitled. We also looked at Deprivation of Liberty Safeguards (DoLS). DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests.

People living at Phoenix House Care home varied in their capacity to make decisions regarding their care. The provider informed us a number of 'best interest' meetings had been held. The care files we looked at did not contain any recorded mental capacity assessments nor 'best interest' decision making records. The provider informed us they did have this documentation but it had been removed on information that they had been given by two different visiting professionals. Our discussions with the provider suggests this may well have been a misunderstanding related to the requirements of a DoLS application and not in respect of these records. We looked at these records and found them to be fully completed and compliant with the requirements of the MCA. The provider confirmed these would be placed back in people's files.

With regard to the use of bedrails to help keep people safe the use of this equipment can be considered a form or restraint or restriction under the MCA. We did not see a 'best interest meeting' or discussion with relevant parties regarding this. We brought this to the attention of the provider during the inspection and following the inspection we were informed that a meeting had been held to discuss consent to their use.

Although care staff did not have a theoretical knowledge of the MCA legislation they appeared to be integrating the principles of the MCA into their practice which helped to

Good

Is the service effective?

transform the experience of adults with care and support needs. For example, assisting people to make a choice, giving people time and assisting them with their decision making when necessary.

Staff told us by talking with people they obtained their consent to assisting them with daily activities and care and relatives told us they were consulted regarding decisions about their family member's care.

A care plan relatives' approval form was in the care files we looked at. This held brief information about the care needs of the person and had the potential to be misleading and possibly suggest implied consent. Whilst clearly relatives should be consulted and their wishes considered they (in the absence of legal authorisation) cannot consent on behalf of a family member. We advised the provider of this.

The provider and manager had knowledge of the workings of the MCA and discussed with us how this applied to the service provided. The provider had applied for DoLS authorisations for a number of people. We found the provider knowledgeable regarding the process and they were working with the supervisory body (Local Authority). Documentation was in place to support this. For the three approved authorisations, records indicated that the supervisory body had yet to appoint a relevant person's representative to represent and support the person. We advised the provider to raise this with the supervisory authority to ensure people's rights were protected in accordance with the MCA. The provider told us they would act on this.

At the last inspection in October 2014 we found the provider did not ensure people were protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained. This was in relation to restrictive practices, such as the use of lap belts and records did not give a clear indication of the current legal status or monitoring of people who were on DoLS authorisations. As a result of our findings during the inspection in October 2014 a compliance action was issued to the provider requiring them to take swift action to make sure accurate and appropriate records were kept. The provider sent us an action plan which showed us the actions they were taking to advise us accurate and appropriate records were now being kept safely.

At this inspection we looked at a number of records including records around restrictive practices and DoLS documentation. We found this had improved.

Two members of staff had not had any experience of using physical restraint but both were aware that two people had lap belts in place for intermittent use to protect them from falling. They were both clear that this constituted a restraint and that the belts could only be used for a maximum of two hours daily. Care plans recorded the use of the lap belts and were subject to review. DoLS authorisations were in place. This meant that appropriate decisions had been made and were recorded about the use of restraint and the use of restraint was minimised in the way that is intended by the MCA (2005).

The provider told us three people had a DNAR (do not attempt resuscitation) in place. The provider informed us they were seeking guidance around how people's mental capacity was assessed in respect of these DNARs and whether this was to be reviewed further.

We looked at how meals were organised. The main meal was prepared at Maryland Care Home and transported to Phoenix House Care Home in suitable heated containers.

Three main meals were served each day. Breakfast consisted of a choice of cereals, porridge and toast. There was no cooked option. The main meal of the day was served at lunch time and this comprised of two courses. A lighter meal was provided at tea time and supper before retiring. We saw drinks being served at different times of the day. The dining room tables were nicely set with centre pieces and tablecloths. Coloured plates and cups had been introduced in accordance with good dementia care practice. They were red in colour which because of the dark consistent colour, facilitated people to identify different foods on their plate.

Lunch time was calm and unhurried. People received assistance according to individual need and were offered a choice of hot and cold drinks. The main meal looked plentiful and appetising. A vegetarian option was available.

There was a picture menu displayed in the dining room. People were approached each day to select their choices for the following day and the menu board was used to help people choose. During our inspection however the menu

Good

Is the service effective?

board did not reflect the meal of the day. Menus were available in the kitchen though people were not given an individual menu to look at. Staff said this would be provided if requested.

People told us they had plenty of different meals which they said were well cooked. One person said, “The food is always served hot and there are plenty of cups of tea which I like.”

There were several examples in the home where the provider and manager had actively sought guidance on and researched ways in which the lives of those suffering from dementia could be enhanced and their abilities maximised. This consequently facilitated people retaining independence where at all possible. For example, a recent decoration scheme had drawn on ideas that matt paint was preferable to gloss because of the reflective qualities of the latter which can be disabling to people with reduced vision and cognitive difficulties. In the same vein, veneer panes that resembled exterior doors of different colours had been placed on bedroom doors to help people identify their room. One veneer pane needed to be replaced; this was brought to the manager’s attention during the inspection.

People had a choice of two lounges and a dining room to sit in. In the dining room there was an area decorated with 1950’s wallpaper and fire place. This was set up as a reminiscence area. There were framed posters of food and drink items from the same era as a memory aid. This provided a quieter area for people to sit.

The provider had researched the use of photographs on people’s bedroom doors and some guidance indicated that people with memory problems might not recognise themselves and find current photographs of themselves unrecognisable or even hostile. However, if a person requested a photograph on their doors the provider said this would be done. Alternatively, people had the option to put any identifying feature they would find helpful, for example posters by grandchildren.

Good

Is the service caring?

Our findings

Throughout the inspection people staff spoke with people in a respectful manner. People were called by their preferred name and staff readily understood their non-verbal communication. People told us the staff were polite and spoke with them in a kind and helpful manner. Over a lunch time we found some staff did not engage people in conversation whilst assisting them with their meal. For example, there was no general chat about day to day news or checking to make sure people were enjoying their meal. We brought this to the attention of the provider during the inspection. At other times staff communicated well with the people they supported.

Over the two days the home was busy and there was lots of activity going on. We observed the staff supporting people in a caring, respectful and discreet way. Staff responded to people in accordance with their need. If staff were helping someone else they explained they would be with the next person as soon as possible. Staff displayed a genuine warmth and understanding of the people they supported. A staff member reported, "We all get on well, we are here to do as much as we can."

Staff told us they were clear about their roles and responsibilities to promote people's independence and their rights to privacy, dignity and choice. We heard staff explaining to people what was happening before assisting them. For example, taking a person to the bathroom, offering support with walking or helping them to walk to the lounge to take part in the musical afternoon. Staff discussed with us how they encouraged people to be independent and how they enlisted people's help. People had the use of walking aids and we observed staff encouraging them to use these to help promote their independence.

Staff told us ways in which they protected the dignity and privacy of people, particularly in relation to the provision of personal care. They told us they always ensured bedrooms doors were closed when washing and dressing people. Staff comments included, "We always close curtains and doors" and "We never have anyone fully naked, we ensure that either their top or bottom half is always covered." Staff told us people had a choice of male or female care staff to assist with personal care and a male member of staff said, "I would always ask a female to undertake intimate care anyway."

One person at the home had asked to help staff with a variety of tasks and activities which they enjoyed taking part in to help promote their independence. They told us "The carers do too much for me."

Relatives told us the staff were very caring, polite and kind at all times and there were no restrictions on when they could visit. Their comments about the staff included, "Always kind and helpful" and "You could not have more kindness."

Social history and family background information was recorded in people's care files. The content of which varied however talking with staff confirmed their knowledge about people's lives before coming to the care home. A number of staff had worked at the home for some time and had a good knowledge about people's family life and what was important to them.

Good

Is the service responsive?

Our findings

At our last inspection in October 2014 we found the home in breach of regulations relating to people's care and welfare. At that time the provider did not ensure care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. We issued a compliance action and told the provider to take swift action. The provider sent us an action plan which showed us the actions they were taking to ensure people's care and treatment was planned effectively. They told us people now received the care they needed to meet their individual needs and ensure their welfare and safety. At this inspection we saw improvements had been made.

The care files we looked at were orderly, indexed and easy to read. Information was recorded in respect of people's care needs and staff support. We saw some care plans for medical conditions which had not been in place at the last inspection.

Care documents were reviewed monthly though we found some information remained the same from month to month. They did not always provide evidence of a detailed review. We found not all the care plans contained a level of information that would guide staff in providing personalised care. For example, for a person with confusion there was no information as to what may trigger an episode of confusion and what measures or level of support were needed to reassure this person. However, we saw detailed records around personal hygiene and sleep patterns. Staff we spoke with were knowledgeable regarding people's care and this included any changes in their condition, current risks to their health and support for episodes of agitation. A staff member told us about the importance of making sure people had the right sling when using the hoist and how a person's clothing had been adapted to ensure their comfort and wellbeing.

Care files contained sections regarding 'what people could do for themselves', 'needs help with', 'gender preference for personal care' and some information on social background. Wider range of needs included daily activities such as hygiene, communication, elimination, personal care, medicines and medical conditions. Staff were able to tell us what people preferred such as, choice of clothes, food, bathing requirements and what people liked to watch on television. Staff said, "I give people a choice of what they want to wear, I get clothes out and show them" and "We encourage residents to take part in the singing but if they don't want to then that is their choice. We will sit quietly somewhere else."

Staff told us they received hand overs at shift changes where people's care provision was discussed. The manager being new in post informed us they were going to review all the care documents and record more detail around people's care needs, social care and staff support. Following the inspection they informed us these care reviews were underway. Although some care files lacked detail we did not observe any one not receiving the care and support they needed.

We saw relatives were involved with planning their family member's care. A relative told us how they were kept up to date and involved with the care their family member received. They confirmed they were kept up to date regarding changes or if their family member was unwell.

The home did not employ an activities organiser. Staff helped to arrange social activities or an outside entertainer visited the home. We saw that people were offered a variety of activities that were thought out, stimulating, enjoyable and appropriate for the needs of those living with dementia.

There was a board in the dining room showing a programme of twice daily events. These were implemented by staff and included wartime music, chat with picture books, reminiscence box, bingo, painting and jigsaws. In addition, there was a facility to provide an audio programme of local news and events and an activity table. There was a keep fit session, run by an external facilitator as well as two different singers, one every week. The home had Wi-Fi connection which people accessed.

A number of people had physical or sensory needs, for example impaired sight. Through a specialist organisation, jigsaws had been acquired suitable for people with cognitive difficulties, as well as physical difficulties. A published weekly audio broadcast on local news and events was available via a data stick. In this way the service had established a link to an organisation that provides sector specific guidance linked to best practice in the delivery of care.

The provider had plans to develop a sensory garden and to install raised beds in the enclosed garden.

Good

Is the service responsive?

During the inspection the activity was a singer with guitar, who sang mostly 1950's songs. An assistant supported the singer by interacting with people, and where possible, dancing with them. There were relatives joining in as well. This was very lively and enjoyable; there were lots of smiles and hand and foot tapping and everyone was very animated. One person who had been sitting slouched forward and appeared not very interested got up and reached their arm out to a nearby member of staff, indicating they wanted to dance. Staff responded immediately. The event was enjoyed by people at the home, relatives and staff. It was clear evidence of how people's lives were enhanced with the right kind of stimulation.

At different times of the day we saw staff sitting with people on a 'one to one' basis talking about topical events and the news of the day. A person told us they enjoyed this 'quiet' time.

Details of the service's complaints procedure was available in the home's service use guide. The complaints procedure along with a comments book was also readily visible and accessible in the entrance hall of the home for people to access. A person we spoke with told us they knew who to speak with if they had a concern. Relatives told us they would go to the owner or manager if they had a complaint.

Staff said they would always try to resolve any complaints made to them 'if at all possible'. A staff member commented, "If I could rectify I would, if not it would be put in the concerns file and in the handover book. Although we have not had any concerns for a while." We saw the complaints file and any concerns or complaints made had been addressed and a response made. In this way staff were ensuring people were listened to and information given to them was dealt with appropriately and in a timely way.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection the service had a registered manager. The registered manager was newly appointed. The manager also held the position of registered manager for another care home owned by the same provider. The manager informed us their hours were split between the two homes and they were always available by phone and that both homes were in close proximity of each other. Staff informed us the manager was easily contactable and always responded.

The home had a number of systems in place to monitor the quality of the service provided and drive improvements. The provider conducted a monthly audit (check) on how the home was operating. The manager's report included information pertaining to medicines, accidents/incidents affecting people's safety, care plans, spot checks on people's rooms, assessing cleanliness and speaking with people living at the home. Where the audit identified an increase in risk, for example, where a person had suffered an increase in falls, actions had been taken to help minimise the risks. This included seeking advice from an external professional and use of equipment to help promote the person safety. In other areas, the audit lacked detail with regard to the content of the checks. The provider had carried out audits to determine how well medicines were handled. These checks however, did not always fully assess all aspects of medicines management within the home so had failed to spot many of the concerns and discrepancies that we found during our visit. This meant the system of audit in place was not sufficiently robust to identify concerns and therefore make the improvements necessary to ensure medicines were handled safely within the home.

The manager advised us of the actions they were taking to ensure people's care records were more detailed and tailored to people's individual needs. We have since received confirmation from the manager that the care documentation reviews were now taking place. Since starting at the home the manager had made some changes to the environment. This included more pictures in communal areas and signs to promote a more dementia friendly atmosphere. A person who lived at the home said, "I like the changes, the home is better for it."

Staff informed us the management of the home was open and transparent. Staff were positive regarding the overall management and the leadership by the manager. Staff comments included, "The home, it's got a good heart here, we love all the residents, it is a happy home and everyone is getting on. We have good leadership and everyone likes working here", "Here we have a nice, happy, friendly atmosphere. Everything works well. Morale has increased over the last few months, any issues we speak to the manager who is very approachable" and "The home runs well." Staff told us they were supported by the manager and provider and they would be confident in speaking to them if they had a concern.

Staff we spoke with were aware of the home's whistle blowing policy and they said they would use it.

We checked various safety certificates such as fire safety, legionella, gas, fire safety and electrical safety; we found they were up to date.

Infection control standards had been assessed. In February 2014 an external audit had been completed by an external community health team and a score of 95% awarded. In November 2014. The provider undertook an infection control audit using the same format to ensure good standards of hygiene were being maintained. No issues were recorded. The manager informed us they completed visual checks of the cleanliness of the building and reviewed cleaning records to endure they were current. In 2014 the home had recently achieved a four star rating for food hygiene practices.

We asked how people living at the home and relatives were able to feedback their opinions regarding how the home operated. We saw that in November 2014 people who lived at the home and their family members had been given satisfaction questionnaires about the service provided. Overall, comments received were positive and the provider had taken action in respect of information received. .

People who lived at the home attended a residents' meetings in December 2014. Topics discussed included entertainment and catering arrangements. A person told us, "The meetings are a good get together but you can always suggest things at other times."

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The provider had sent notifications to us of significant events.

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 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The provider did not have appropriate arrangements in place to manage medicines safety to fully protect people against the risks associated with medicines, this was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

The enforcement action we took:
A warning notice was issued with a date of 30 June 2015 to meet requirements