Boulevard Care Limited

Boulevard House

Inspection report

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Lincolnshire
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Boulevard House is a residential care home providing accommodation and personal care to up to 15 people. The service provides support to people with a learning disability. The accommodation comprises of a bungalow with 3 bedrooms and a main house with 12 bedrooms. At the time of our inspection there were 12 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 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; the policies and systems in the service did not support this practice.

Physical intervention was used by staff who had not received the necessary training by a certified training provider.

Incident forms did not contain enough information to explain what had happened and what physical interventions staff had used on people. It was not clear if physical interventions were safe or justified.

One person's wardrobes were locked without consent. The provider had not completed a mental capacity assessment or carried out a best interest meeting to evidence locking the wardrobe was in the person's best interests.

There were no protocols for 'as required' (PRN) medicines which were used to manage distress. When PRN medicines were given to people, records were not thorough or detailed. There was no evidence of post incident analysis or review of PRN medicines when they had been used to support people in distress.

Right Care
People were not supported in a way that promoted their dignity and human rights. There were significant concerns on how people were supported when they were distressed.

Lessons were not learnt, and improvements were not made when things went wrong. Staff did not learn from incidents to ensure people had better experiences and positive outcomes.

Risks were not identified or assessed which put people at risk of harm.

Right Culture
We identified a closed culture in the service. A closed culture is a poor culture that increases the risk of harm. Language used in care plans showed a controlling culture. A care plan referred to 'house rules.'

The provider had not taken effective action to identify and address the poor culture in the service. Governance systems in the service were ineffective as they failed to ensure regulatory requirements were met.

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 22 January 2020).

Why we inspected
This inspection was prompted by a review of the information we held about this service.

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.

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 have found evidence that the provider needs to make improvements. 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 Boulevard House on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to consent, safe care and treatment, safeguarding people from abuse and improper treatment, good governance and staffing at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
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? The service was not Safe. Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not Effective. Details are in our Effective findings below.	**Inadequate**
Is the service well-led? The service was not Well-Led. Details are in our Well-Led findings below.	**Inadequate**

Boulevard House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (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
One inspector carried out the inspection.

Service and service type
Boulevard House 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. Boulevard House 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 provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a manager in post who had completed their application to be registered. They became registered during our inspection period.

Notice of inspection
This inspection was unannounced on the 7 November 2022 and the 24 November 2022.

What we did before the inspection
We used information gathered as part of a monitoring activity that took place on 26 July 2022 to help plan the inspection and inform our judgements.

We sought feedback from the local authority and professionals who work with the service including Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.

We used all this information to plan our inspection.

During the inspection
We spoke with 5 people who use the service and 1 family member about their experience of the care provided.

We spoke with 5 members of staff including the manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included 2 people's care records and 2 medicine records. We looked at 2 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

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.

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

- Positive behaviour support (PBS) plans were not in place for people who required them. PBS is a person-centred plan that promotes quality of life and helps staff to support people in distress to keep them safe. People's care plans did not contain enough information about risks to people's safety and actions staff should take to help manage this.
- Staff did not record enough details on how they physically intervened and restrained people when they were distressed. Records showed frequent use of restraint and physical intervention, however details of how staff did this, how long for or who had been involved were not always included. This increased the risk that people were being restrained in a way which was not safe or proportionate. This also meant people and staff were at increased risk of injury.
- Restrictions were in place for people without appropriate review. We found 2 people had their wardrobes and drawers locked due to historic behaviours. Restrictions had not been reviewed to ensure they were still justified and the least restrictive approach. We did not find evidence people still needed to be restricted in this way.
- Language used in care plans and incident reports showed a culture of control. For example, a care plan stated, "[Person] is aware of the house rules within Boulevard House and generally abides by them." Furthermore, we observed inequality when a staff member drank in the lounge, but people were told they couldn't in case of spillages.

The provider did not ensure appropriate systems and processes were in place to prevent the risk of abuse. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Preventing and controlling infection

- Known risks to people were not always assessed or managed consistently. We found; relevant risk assessments had not been carried out for a person who was known to run away when they were distressed. There were no risk assessments in place to support someone who was known to self-harm and no risk assessments were undertaken following another person going to hospital following ingesting something not safe for consumption. This meant risks were not always managed and staff did not have information to follow to support people consistently.
- Care plans did not contain up to date information on people's complex needs. For example, one person's care plan stated, '[Person] has displayed physical challenging behaviours, these are a lot less frequent now they've moved into Boulevard Care.' However, due to recent incidents this person had been referred to an assessment and treatment team who provide intensive support to people who are experiencing an increase in distress.

● People were not empowered to raise concerns about their care and treatment. For example, it stated in 1 person's care plan they had made allegations in the past and was known for doing this in prior placements. It did not state that allegations should be taken seriously and what procedures staff needed to take if the person raised concerns to keep them safe. This made the person more vulnerable to abuse.
● Staff were not using PPE in line with current guidelines. On arrival to the service we saw staff not wearing face masks. This increased the risk of infection spreading. The provider told us they did not know they still needed to wear masks. We signposted the provider to up to date information; following this they ensured all staff were wearing masks.
● The provider was not promoting safety through the layout and hygiene practices of the premises. There were no clinical waste bins in the home which was not in line with standard waste management precautions. This meant there was no safe procedure to dispose of infected waste.

Using medicines safely
● Medicines were not always stored in line with good practice. For example, we found PRN medicines stored with controlled medicines. Controlled medicines are prescribed medicines that are subject to strict legal controls. Controlled medicines should be stored in a dedicated cupboard separated from other medicine, so they are not accessible to unauthorised people.
● Medicine stocks were not safely managed. We reviewed a balance check for controlled medicine and found it had been pre-recorded for 3 days. This meant balance checks for controlled medicines were ineffective as counts should only be carried out after administration.
● Protocols were not in place for people's 'as required' (PRN) medicine. When people were prescribed medicine to help with anxiety or distress, staff did not have the appropriate information to ensure medicine was made available and not overused.
● Protocols were not completed for people who were prescribed PRN cream. Additionally, topical medicine application records (TMAR's) were not available to give staff directions where to apply creams when people needed them.

Risks relating to the health, safety and welfare of people were not managed safely. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following feedback, the provider was responsive to our findings and created an action plan to make improvements.

Staffing and recruitment
● Staff were supported by the manager or team leader on each shift. This meant the manager had limited time to complete their own role and responsibilities which resulted in regulatory requirements not being met.
● Staff were safely recruited. Pre-employment checks such as Disclosure and Barring Service (DBS) had been completed before staff started work. Checks provide information including details about convictions and cautions held on the Police National Computer.

Visiting in care homes
The provider had visiting arrangements in place that aligned to government guidance.

Inadequate

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.

- People were not receiving support in line with the MCA.
- Mental capacity assessments were not completed for decisions relating to people's care or treatment. This meant decisions had been made on behalf of people, such as searching one person's room for items that could be used to self-harm and locking another person's wardrobe due to historical behaviour. There was no evidence capacity assessments or best interest meetings had been carried out in relation to these decisions to ensure they were in people's best interests and the least restrictive options.

The provider had not complied with the principles of the Mental Capacity Act. This was a breach of regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
- Staff used physical intervention techniques they had not been trained in to restrain people. Incident records showed staff were regularly doing this when people were distressed. People were exposed to the risk of unsafe support as staff did not have the appropriate skills or training to enable them to respond safely when people experienced distressed reactions.
- New staff had not always completed the provider's mandatory training or induction programme. For

example, training records showed 1 staff member had not completed any training after being in post for 8 months, and another had not started any training since being employed in September 2022. In addition, staff were not always signed off as completing their induction. This increased the risk of people not being effectively supported by appropriately trained and skilled staff.

The provider had failed to ensure staff were provided with training appropriate to their role which put people and staff at risk. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff received regular supervisions and appraisals. The manager showed us their schedule which ensured staff were receiving regular support. Staff told us they felt supported in their role.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● We identified some instances in records and plans where language and terminology used was outdated and did not support equality and diversity. For example, one person's care plan stated staff needed to be aware [person] liked buying items that weren't appropriate for their age and gender. This does not reflect best practice and can be regarded as undignified and offensive.
● People were not fully involved with their care planning. For example, although people had signed their care plans there was no evidence they had been consulted about how they wanted to be supported and kept safe. Information was not available in easy read formats to support people's understanding. This meant people did not have control over how their care and support was being delivered.

The provider had failed to ensure people were receiving person centred support. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
● People were not allowed to drink in the lounge. We observed staff telling people they could not drink in the lounge in case they spilled their drinks. Although people were accepting of this, it prevented an inclusive environment.
● People had been supported to personalise their bedrooms. Bedrooms appeared very comfortable and reflective of people's personalities and taste. People we spoke with were proud of their bedrooms and keen to show them off which supported dignity and self-worth.

Supporting people to eat and drink enough to maintain a balanced diet
● Food was home cooked and of good quality. There were options available at mealtimes and people could request something different which supported people's experiences at mealtimes.
● People were supported to have enough to eat and drink. The manager told us people told them what they liked to eat, and it was incorporated into menus. This encouraged people to have choice and control.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People were referred to healthcare services when required. We saw examples in care plans of people being supported to visit GP's and attend annual health checks. This encouraged people to maintain good health and wellbeing.
● Care plans included specific information relating to people's healthcare needs. We saw correspondence from health care professionals which evidenced collaborative working.

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

- Governance systems and provider oversight were not effective in ensuring people were safeguarded from abuse and discrimination. The manager told us another manager reviewed incident forms to assess quality. However, this was ineffective at identifying and addressing restrictive practice and a closed culture.
- Practice that deprived people was not identified. The provider failed to review ongoing restrictive practice that required regular review to ensure it was still a proportionate response to the risk presented. This meant people had been potentially subjected to unjustified restrictions.
- Information was not always up to date, accurate or properly reviewed. Care plans had not been updated to reflect learning from incidents or changes in people's needs. This meant people were at risk of not receiving appropriate care and support.
- Medicine audits were not effective at identifying issues we found during our inspection. For example, as cited in the safe section of the report, the absence of PRN protocols and information missing in medicines records. As a result, people were at risk of their medicines not being managed or stored safely.
- Actions had not always been taken to address known issues. Lincolnshire Healthwatch had visited on the 26 September 2022 and made recommendations that clinical waste bins were purchased to comply with waste management guidelines. However clinical waste bins had still not been purchased on the first day of inspection on the 7 November 2022 which meant there wasn't appropriate waste management procedures to dispose of infected waste.
- The provider had not created a culture of learning and continuous improvement of people's care experiences. Blanket statements were used in incident records, such as, 'Physical intervention should be used when all other methods have been tried and if there is a danger of harm to [people] or others around them,' and, 'No lessons could be learnt from this.' This meant incident reports were not sufficiently reviewed to reduce risks to people.

The provider had failed to assess, evaluate and improve their practice to monitor and improve the quality of the service and keep people safe. 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; Working in partnership with others

- People were offered questionnaires to provide feedback. The last questionnaire was issued in September

2022. The manager told us they had collated suggestions and put actions in place to support people's involvement in improving the service.

● Family questionnaires were last issued in August 2022. Although there was little response from these, a family member told us they received questionnaires and were happy to put their views across.

● Staff meetings were regularly scheduled. Staff told us meetings were mostly every month and it was an opportunity for them to raise any suggestions. Staff told us they were confident managers listened to them.

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

● Safeguarding procedures were not in place to report concerns. The manager told us they hadn't had to raise any safeguarding concerns so there wasn't an embedded system at the time of inspection. However, staff did know how to raise concerns if they needed to.

● The manager told us they knew how to report notifiable incidents to relevant agencies, including the local authority and the Care Quality Commission. They explained when they would involve and notify other people although stated they had not had to yet.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure people were receiving person centred support.

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 11 HSCA RA Regulations 2014 Need for consent The provider had not complied with the principles of the Mental Capacity Act.

The enforcement action we took:

A warning notice has been issued to the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks relating to the health, safety and welfare of people were not managed safely. Information was not always relevant and up to date which put people at risk.

The enforcement action we took:

A warning notice has been issued to the provider.

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 The provider had not complied with the principles of the Mental Capacity Act.

The enforcement action we took:

A warning notice has been issued to the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, evaluate and improve their practice to monitor and improve the quality of the service and keep people safe.

The enforcement action we took:

A warning notice has been issued to the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure staff were provided with training appropriate to their role which put people and staff at risk.

The enforcement action we took:

A warning notice has been issued to the provider.