Derbyshire County Council

9 Victoria Street Care Centre

Inspection report

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Date of inspection visit:
13 April 2018

Date of publication:
08 June 2018

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 13 April 2018 and it was unannounced. It was completed by one inspector. At the previous inspection on 7 December 2015 the service was rated good.
9 Victoria Street is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. It is a care home registered to support 18 people with learning disabilities. This is a large service which was registered with us prior to the development and publication of Registering the Right Support and other best practice guidance. These state that the service should be designed and developed in line with the values of choice, promotion of independence and inclusion. People with learning disabilities and autism using the service should live as ordinary a life as any citizen.

We found that the planning of the service did not always meet these principles. There were not always enough opportunities for people to plan and achieve their goals. They were not always included in the planning and managing of their home; for example, choosing when and what to eat. When they raised concerns they were not always satisfied with the outcome. Complaints were also not always managed in line with the provider's policy. Some staff felt that the service was not as person centred as it could be and that when they raised those concerns they were not always listened to.

When people could not make some decisions for themselves these were not always assessed or legal safeguards applied for. This meant that people were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered 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. The registered manager understood their responsibilities to ensure that we were informed of events in line with their registration. They ensured that audits and quality checks were completed so that people received safe care and treatment.

Risk was assessed, reviewed and managed to keep people safe. They received their medicines as prescribed and they were stored and managed well. There were enough staff to meet people's needs safely and they had been recruited to ensure they were safe to work with people. The risk of infection was also controlled.

People had enough to eat and drink and any specialist dietary needs were catered for. They were supported to attend health appointments and to monitor their health. When specialist support was needed this was sought so that staff provided care in line with national best practice guidelines. Staff knew people well and had caring relationships with them. They respected their privacy and encouraged their independence. Relationships with families and friends were encouraged and developed.

Staff received training and support to do their job well. They maintained care records on a daily basis which highlighted any changes to people's support and this was communicated clearly.

The environment was being reviewed and modernised to meet people's needs. Information was displayed in the home in an accessible way for people to understand. There was no one receiving end of life care and so we did not inspect this.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.
People were protected from abuse by staff who understood their responsibilities. There were systems in place to assess and manage risk, including around medicines. There were enough staff to meet people's needs safely and they had been recruited to ensure they were safe to work with people. The risk of infection was controlled and the environment was clean and well managed.

Is the service effective?

Requires Improvement

The service was not consistently effective.
People's ability to make their own decisions was not always assessed and there were not always legal safeguards in place to protect them. The environment was being reviewed to meet people's needs. Staff received training to do their jobs well, including receiving information to meet national guidelines and best practice. People had enough to eat and drink and were supported to access healthcare.

Is the service caring?

Good

The service was caring.
People had caring relationships with the staff who supported them which was based on respect. Their dignity and privacy were upheld. They were supported to develop and maintain important relationships.

Is the service responsive?

Requires Improvement

The service was not consistently responsive
People were not always supported to plan their support to ensure that they achieved goals and developed their independence. When they raised concerns they were not always satisfied with the decisions. Complaints were not always managed in line with the provider's procedure. Information was shared in an accessible way.

Is the service well-led?

Requires Improvement

The service was not consistently well led.
The principles of the service did not always ensure that people's

preferences and inclusion was a priority. Some of the actions that the provider set to improve the service were not implemented. Other audits and quality checks were effective in ensuring that people were receiving a safe service.

9 Victoria Street Care Centre

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.

We completed this unannounced inspection on 13 April 2018. It was completed by one inspector. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used this and other information about the provider that they had sent us through notifications to assist us to plan the inspection.

We used a range of different methods to help us understand people's experiences. People who lived at the home had varying levels of communication. We spoke with six people and also observed the interaction between people and the staff who supported them throughout the inspection visit.

We spoke with the registered manager, two deputy managers, and four care staff. We reviewed care plans for four people to check that they were accurate and up to date. We also looked at the systems the provider had in place to ensure the quality of the service was continuously monitored and reviewed to drive improvement. We reviewed audits and quality checks for medicines management, fire risk assessments, health and safety checks and infection control. We reviewed staff training records, minutes of meetings and the dependency tool used. We looked at complaints and two staff recruitment files.

We asked the provider to send us additional information about staffing, complaints and training after the inspection visit and they sent this to us within the agreed time span.

Good

Is the service safe?

Our findings

People were protected from abuse by staff who understood how to identify signs and report in line with procedures. One member of staff said, "I would report anything that worried me to one of the managers immediately". We saw that there were notices in communal areas so that people knew where to report any worries that were written in an accessible format which people understood. There had not been any safeguarding concerns reported since our last inspection and when we spoke with staff and reviewed records we were assured that this was accurate.

Risk was managed to protect people from harm. We spoke with one person about the arrangements that had been put in place to protect them from harm. For example, they told us that they had moved bedrooms so that they were in a safer environment. Staff talked to us knowledgeably about the risk management systems that were in place. This included staffing ratios and equipment to safely evacuate the building in case of emergency. We reviewed records and saw that there were risk assessments in place which were reviewed if anything changed. Some people could behave in a way which would cause them or others harm. We saw that there were plans in place to support staff to understand the circumstances which may cause this behaviour as well as guidance to help them understand how to engage the person to reduce the risk of the behaviour continuing or escalating. Records were maintained of any behavioural instances and this included what action was taken afterwards to avoid future repetition. This demonstrated to us that there were systems in place to learn when things went wrong.

The environment was regularly checked to ensure that it was a safe place to live. We saw staff checking fire equipment on the day of inspection to ensure it was correct. One person we spoke with said, "We sometimes practise leaving the building in case of a fire and I go through the fire door by my room". Records that we looked at demonstrated that the environment was regularly checked including a fire risk assessment.

There were systems in place to reduce the risk of infection within the home. We saw that the home was clean and that there were staff employed specifically to maintain this. Staff we spoke with talked to us about the arrangements in place to reduce infection; for example, rules they needed to follow when they prepared food including the use of protective equipment. We also saw the provider had been rated as five stars by the food standards agency; this is the highest rating awarded. The food standards agency is responsible for protecting public health in relation to food.

There were enough staff to ensure that people's needs were met safely and the staffing levels were reviewed against the number of people living at the home. One person we spoke with said, "There are enough staff because there is always someone around when you need them". Another person said, "I have an alarm in my room that I can press if I need someone at night and there is always someone who can come". Staff told us that there were enough staff to be able to support people at home but that staff deployment meant that sometimes there was only one staff member supporting people while the other had management duties in the office. We spoke with the registered manager about this who recognised that there needed to be clarity about the staff roles and responsibilities when there were only two on duty. There were different staffing

levels throughout the week and additional support provided if people had pre-arranged appointments. For example, one person had had an evening out on the previous night which additional staff were available to support.

The provider followed recruitment procedures which included police checks and taking references to ensure that staff were safe to work with people. Staff we spoke with confirmed that this had taken place and we saw records which evidenced it.

Medicines were managed to ensure that people received them as prescribed. One person told us, "The staff do my medicine and I can ask for painkillers if I have a headache". Staff told us about the training they received to administer medicines. One member of staff said, "I have given medicines in my previous role but I won't do it here until I have done the training with them". Some people were prescribed medicines to take 'as require' and we saw that there was guidance in place to assist staff to know when this should be given. The medicines were stored, recorded and monitored to reduce the risks associated with them. If there were any errors in the administration or recording of medicines they were recorded and we saw that they were reported to the registered manager who addressed it with individual staff. This demonstrated to us that the systems in place to assess and address mistakes were effective.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that some decisions had been considered under the MCA and assessments had been completed, for example, in relation to leaving the building unsupported. However, other decisions had not been assessed. For example, one person had a health condition which they told us, and staff confirmed impaired their ability to make certain decisions. This was recognised in the records we reviewed but a capacity assessment was not available. The registered manager told us that they thought that one had been completed by a social worker but it had not been read in the service. We were told about the restrictions that had been put in place to help the person to manage this condition, but a DoLS had not been considered to ensure that the restrictions were legally authorised. We also reviewed DoLS which had been approved and we found that one had conditions on it. When we spoke with the registered manager they were not aware of the conditions or their responsibility to comply with them. These conditions were in place to ensure that the person was supported in the least restrictive way possible and encouraged to develop interests and independence. We also saw that one other person's DoLS was out of date and the registered manager could not locate a more up to date one. This meant that we could not be assured the person was supported in line with the legal safeguards which had been put in place to protect them.

This is a breach of Regulation 11 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

The environment was in progress of being renovated and updated to meet people's needs. In the PIR the provider told us that 'Improvements in the building are being actively introduced by the management team to ensure that clients can live in an environment that helps their needs to be met and to assist in increasing their independence'. We saw that there had recently been a bathroom and toilet refurbishment and that the building had been re-decorated. The registered manager told us, "We recognise that the building is not as modern as more recently built ones. We are also reviewing the fact that a lot of the people who come for a short period of time are younger and we are trying to ensure that the re-decoration meets their taste; for example, brighter colour furnishings". We also discussed the accessibility of the home because there was no lift for people with mobility needs to be able to access the first floor rooms. The registered manager said, "This sometimes limits who we are able to offer a place to". This demonstrated to us that the provider recognised the limitations of an older building but were making efforts to ensure that it met people's needs within those.

Staff had training and support to do their jobs well. One person said, "The staff are all good and know how to support me when I need it". One member of staff told us, "We have regular training and updates and it is monitored to remind us". Another member of staff said, "I am doing food hygiene here soon. If there is no cook available then we make the meals and so I need to update it". We reviewed training records with the registered manager and saw that they were monitored and regularly reviewed.

Staff received regular supervisory meetings in order to be able to develop in their role. One member of staff told us, "We do have regular supervisions which are an opportunity to discuss any further training and support that I want".

People had enough to eat and drink and there were systems in place to monitor them if they were at risk. For example, some people had conditions which meant that their food intake needed to be monitored and there were arrangements in place for this. It also meant that some drinks and snacks were not readily available for people to access. However, we saw that people were offered drinks throughout the day and that staff made them for them when requested.

There was information available to staff to ensure that they understood how to support people in line with national guidelines in relation to their healthcare. For example, there was guidance available for them to understand certain health conditions and the impact on people's lives. There was also information readily available in relation to people's medicines; for example, when one health professional had changed one person's health monitoring a record of this was maintained alongside their MAR. The registered manager said, I think that it is important that the staff understand the reasons for monitoring and change so that they follow the guidance". This demonstrated to us that people's needs were assessed and outcomes were clear, including working to best practice in some areas.

People had their healthcare needs met. One person told us about the arrangements that were in place to support them to regular health appointments including specialist support. One person was visited by a health professional at home on the day of the inspection and we saw then supported by staff throughout it. We saw another person attend a health appointment outside of the home with staff support. On their return the staff member completed information about the appointment, completed a diary entry for a future appointment and offered the person support and reassurance. We looked at additional records and saw records that we reviewed showed that people's healthcare was monitored and reviewed. This meant that people were supported to maintain good health and to access healthcare services.

Good

Is the service caring?

Our findings

People had caring relationships with the staff who supported them. One person told us, "The staff are all nice and kind. I can talk to them about how I am feeling". We saw that the staff knew people well and we observed that they spent time speaking with people about their day and how they were. They were gentle in supporting people to be independent; for example, one person asked for support to mobilise and one staff member spoke with them and encouraged them to use their equipment to move independently. Other people could independently go out to attend activities or meet friends. The registered manager told us, "Some people do go out independently for some areas of their lives but ask us to support them for others; for example, attending appointments". People made choices about their care and one person told us, "I spend time in my room when I want to and staff don't intrude". Other people asked for support when they required it; for example with personal care.

People's dignity was promoted and they were treated with respect. One person told us, "I have a key to my room. The staff always knock on the door if they need me". We saw that when one person had a health appointment they were supported to a private area to do it. People were supported to speak with us independently in a private area so that they could talk to us without staff present if they wanted to. One person showed us their room and we saw that it had been personalised with their own belongings and was homely. Another person had set up a games console in a second lounge so that they could play without disturbing people who were watching television.

Social networks and friendships were supported and encouraged. One person told us, "My family visit every weekend. They arrange it with me". Other people told us about relationships that were important to them and how they were supported to see those people. There was also a weekly arrangement for a social occasion in the home that had been discussed and agreed at the meetings that people who lived at the home had. The registered manager said, "We recognised that the location of the home could isolate some people and so this is an opportunity to build more networks and friendships in the local community". This demonstrated to us that attention was given to supporting people to develop and maintain important relationships.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive care and support based on their preferences and were not always able to partake in activities of their choice. One person told us, "I am often bored because there isn't enough to do. When I ask staff if we can go out, they usually say they will have to see if there are enough staff on. I hate Saturday's because everything comes to a halt". When we spoke with staff they confirmed that the staffing levels sometimes meant that they were not able to take people out. One member of staff said, "From a safe point of view we have enough staff and we plan additional staffing when we know people have specific activities planned; for example, we are going bowling next week. However, it would be nice to have more staff at times so that we could be more spontaneous". We spoke with the registered manager who confirmed that the environmental risk assessments stated that there always needed to be two staff in the building and therefore when there were only two staff supporting people the staff would be unable to go out with them. When we looked at staff rotas we saw that there were sometimes only two staff, including on a Saturday afternoon as described. This meant that although people could plan activities and support in advance there were times in the week when they were unable to go out when they wanted to.

There were not always planned activities to occupy people during the day. In the providers improvement plan it stated that, 'A timetable of essential life skills activities to be compiled which will involve an identified member of staff on each shift working with a small number of people (preferably one or two at a time)'. This was not in place and people didn't always opportunity to participate in the running of their home. For example, people and staff told us that there were set meal times and food was prepared by the cook or by staff. People were not supported to prepare their own meals on a daily basis or given the choice of when to eat. One person told us, "We sometimes prepare a meal in the training kitchen but not in the main kitchen". We saw that there was a smaller kitchen available for people to prepare their own food with support.

People did not always have the opportunity to plan their care and support. In the PIR the provider told us, 'As part of a more responsive, caring and involved approach, regular 1:1 weekly sessions with clients are offered with their allocated link worker or other person of their choice. This will be the person's opportunity to have some protected time to speak openly to the person they prefer and share any concerns or worries, to discuss additional support needs, share their dreams and wishes'. When we asked people if they had an allocated link worker they told us that they didn't. One person said, "I am not sure who my link worker is". Another person said, "No, I don't have one named member of staff". We spoke with staff about this and one member of staff said, "We are still named keyworkers but we just fill in monthly reports about what the person has done; we don't have regular meetings with the person. I don't think we are person centred now or focussed on goals for people". This demonstrated to us that people were not as involved in the planning of their support and setting achievable goals as the provider planned them to be.

This is a breach of Regulation 9 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

People were not always happy with the outcome of concerns raised. One person told us that they had asked for a window above their door to be covered as the light was keeping them awake at night. They told

us that they were told that this couldn't be changed. We saw that other rooms did not have this window and that in bathrooms it had been replaced to protect people's privacy. When we asked the registered manager they told us that it was because of fire risk but they acknowledged that this was not consistent with other rooms. They told us that they would review the request from the person.

When complaints were received they were not always managed within the complaints procedure. We were unable to review the outcome of one complaint and we had this information sent to us by a senior manager after the inspection visit. It did not include a response to the person or how happy the person was with the outcome of the complaint.

People we spoke with told us that they knew how to complain and we saw that there was information to assist them with this in the communal area. The information was in an accessible format with pictures and symbols to support this. We saw that other information in the home was written in a user-friendly way according to the Accessible Information Standard; for example, picture menus.

People had care plans in place which were informative and regularly reviewed as their needs changed. Staff we spoke with told us that they could access them easily for guidance. They also maintained daily records and used these to inform handover times when new staff came on shift to support people.

There was no-one receiving end of life care at this point and so we did not inspect this.

Requires Improvement

Is the service well-led?

Our findings

The vision and values of the home were not always based on the principles which we expect from services that support people with learning disabilities; those principles are choice, promotion of independence and inclusion. Three of the people living at the home were not there for short stay or assessment periods and had lived there for over three years. They didn't always have the opportunity to participate in the planning of their care and developing the independence skills to enable them to move to a different setting. The other three people did understand that they were there for a shorter time. One person told us, "I am staying here until I can find my own place closer to my parents' home". The registered manager recognised that it was a period of transition and said, "At one point people had lived here for an extended period of time and we have now tried to change that and quite a few people moved out recently. We are developing relationships with other professional from external agencies to ensure that staying here is a shorter term option and an opportunity to assess where the best longer term home may be". We spoke with people, staff and the registered manager about the decisions in the home and for people we were told that they were made to reduce the risk of harm. However, these decisions did not always balance the person's choice or independence; for example, one person told us about personal care arrangements that they didn't like but had been put in place for their safety. When we asked about another decision the registered manager told us that one of the reasons it was in place was because the person may continue to watch television or play games until the early hours and that their relatives wouldn't like this.

The systems in place to listen to people and staff were not always effective. For example, we saw that the home had received a Healthwatch report where people who lived at the home had given feedback that they couldn't always do as much as they would like to do due to staff numbers and that an action point was set to ensure that staffing levels were adequate to meet individual needs. Healthwatch are an independent organisation who assists people to give feedback about their care by finding out what matters to them and helping their views shape the support they need. People told us that there was still not always enough staff for them to be able to do activities when they wanted to. Furthermore, we saw that the provider had completed a quality review which stated that, 'The minimum number of staff that should be on duty is two care staff and one deputy manager'; again, we found that this was not always followed.

We spoke with staff about their opportunity to give feedback. One member of staff said, "The staff meetings don't always happen; it feels like you bring things up but no action is taken and things are brushed under the carpet". We looked at records and saw that only four staff from a group of seventeen attended. The meeting focussed on saving money and suggested that staff could purchase a day saver bus ticket and then hand this to other staff to reduce mileage claims and encourage people to get the bus. It also recorded that people could be asked to complete an ordering sheet before meals so that appropriate quantities could be prepared to cut down on waste. There was no record that these were solutions that people requested or that they were involved in the decisions.

There was a registered manager in post. They ensured that there were quality audits in place to measure the success of the service and to continue to develop it; for example, audits of medicines demonstrated when records were not fully completed. They had also had audits completed by external agencies such as

the pharmacy which demonstrated that they reached a good standard. Internal audits led to a service improvement plan which had some actions which had been met and others were in progress. Some of the targets were more difficult to track because they didn't have dates set to achieve them. For example, one target was to 'Review and clarify care staff role and responsibilities and to enforce their structured workflow' which did not have clear outcomes or a date for these to be achieved.

The manager ensured that we received notifications about important events so that we could check that appropriate action had been taken. The provider had displayed their previous inspection rating in the home and on their website in line with our requirements.

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 care people received was not always person centred to reflect their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's capacity to consent to their care had not always been considered in line with the Mental Capacity Act (2005)