Pharos Care Limited

The Boat House

Inspection report

24-28 Lichfield Street
Fazeley
Tamworth
West Midlands
B78 3QN

Tel: 01827289654
Website: www.fazeleyjunction.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced inspection took place on 6 January 2017. At our last inspection on 31 March 2016 we found that improvements were required across all of the areas we inspected.

The Boat House provides accommodation and personal care for up to eight people with a learning disability. There were four people living in the home on the day of our inspection.

There was not a registered manager in post as they had left the service. An interim manager was managing the service. 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 overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

People were not always protected from harm and abuse because the provider and staff did not recognise that some incidents should have been reported externally. Concerns identified during the recruitment process were not fully investigated before staff were able to work with people. People who received additional funding for their support did not always have staff with them as planned. Environmental risks had not been considered to ensure people remained safe whilst they were in the home.

Staff induction training did not provide sufficient information and skills for staff to provide effective care to support people living in the home. Some staff had not received a full induction when they started working in

the home. People's diet needed improvement to ensure their health and wellbeing was maintained. There were arrangements in place to support people with their decision making but this had not been maintained to ensure all decisions made were in the person's best interest.

People's care plans did not provide an accurate record of their care, diet and the activities they had taken part in. Care plan reviews did not provide information about changes in care and support needs.

Staff morale was low. Staff felt unsettled because management arrangements were regularly changed. People's records had not been written by staff with an understanding of learning disability. The provider's audit programme had identified some shortfalls in the service but no improvements had been made in response to their findings.

People received their medicines at the right time and in the correct way. People had access to healthcare professionals to support their physical, psychological and mental health. Staff knew people well and interacted with them in a positive way. Relatives were welcomed and knew how to raise complaints and concerns.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.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?

Inadequate

The service was not consistently safe.

Staff did not recognise that some incidents between people constituted abuse and should have been reported externally. Some people had restrictions to their free movement which they had not been able to consent to. Recruitment processes were not suitably robust. Environmental risks had not been assessed and there were no management plans in place to keep people safe. People received their medicines at the right time and in the correct way.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not being encouraged to eat a healthy balanced diet to promote their health and wellbeing. Some staff had not been provided with training to meet the needs of people they supported. There were arrangements in place to support people with their decision making but these had not been maintained to include all decisions. People's health was supported by other healthcare professionals when required.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always recognise people's complex behaviours were associated with their learning disability. People looked happy and relaxed in the company of staff. Staff knew people well and promoted their independence. People were supported to maintain the relationships which were important to them and relatives were encouraged to visit.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not always provided with activities which were the most meaningful to them. People's care plans were reviewed but did not provide updates when changes occurred. There was a complaints procedure in place.

Is the service well-led?

Inadequate

The service was not well-led.

There was no registered manager in post. People's records were not completed contemporaneously to ensure they were accurate. Staff used language when writing about people which did not reflect an understanding of learning disability. Staff morale was low due to frequent management changes within the service.

The Boat House

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 was planned to check 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 inspection visit took place on 6 January 2017 and was unannounced. The inspection was undertaken by one inspector.

Whilst planning the inspection we looked at the information we held about the service and the information contained within the Provider Information Return. The PIR is an opportunity for the provider to give us some key information about the service and their plans for the future. We also spoke with commissioners of the service and the local authority to gain an overview of their interaction with the service.

We were unable to speak with people who used the service so we observed the care and support they received in the communal areas of the home. We spoke with one relative. We also spoke with five members of the care staff, a consultant working with the provider, the interim manager and the quality and compliance manager.

We looked at three care plans for people to see if they accurately reflected the care provided to them. We also looked at four recruitment files and records relating to the management and maintenance of the home.

Inadequate

Is the service safe?

Our findings

Suitable action was not taken to protect people from harm and abuse. The provider had an incident reporting system in place. We read the incidents which had been recorded but found that some incidents met the criteria for safeguarding but had not been reported externally. Staff did not always recognise what constituted abuse and the actions they should take to ensure concerns were reported appropriately. Three members of staff we spoke with were unable to demonstrate what they understood about protecting people from harm and poor care. For example, staff did not recognise that incidents which occurred between people, such as verbal abuse, pushing or grabbing was a safeguarding concern and external discussion and reporting was required. We saw that other incidents that the provider had been aware of, for example a medicine error which had the potential to cause harm had not been reported to us as is required. This meant we could not be assured that there was effective information sharing in place.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person's en-suite bathroom was locked overnight to prevent them from using it. The provider told us this was done to prevent the person from getting into the bath and back into bed whilst wet without the knowledge of staff. Additionally we saw that two other people were restrained by lap straps when they were in their wheelchairs to stop them from getting out. None of the people were able to consent to these restrictions on their freedom. Staff had not recorded why the decisions had been taken or demonstrated that they were in their best interest.

These are breaches of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection on 31 March 2016 we found improvements were required to ensure people's funding for their assessed individual support needs were met. We saw, at this inspection, that members of staff had been allocated to provide one-to-one care for each person but at times they were left alone. One person had risks associated with eating. Their risk assessment stated that they should be observed whilst eating however we saw the person eating their breakfast alone as their allocated member of staff was in the kitchen. Whilst the member of staff was in the kitchen they answered an incoming telephone call and moved into the corridor to be able to speak confidentially. This meant the person was not observed as was required to keep them safe. Another person was being supported by two members of staff working together during the day. When we arrived for our inspection we saw the second member of staff was not providing the planned support as they were assisting with another person. This demonstrated that although the staff levels were planned for people's assessed needs their one-to-one support was not always maintained.

We saw that some environmental risks were not being managed to keep people safe. We read that one person had demonstrated behaviours that challenged their safety and that of others in the kitchen which included throwing some equipment. We found that a drawer which held knives was unlocked and another drawer which was not lockable contained sharp utensils for example vegetable peelers and graters. We read

that another person who used the service was present in the kitchen during this incident. This meant there were no arrangements in place to prevent other people from entering the kitchen or storing sharp items securely to ensure their safety.

These are breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

There was a recruitment process in place. We looked at four pre-employment records and saw that the recruitment of some members of staff had not been satisfactorily completed. For example some people's references and background checks included information that needed further consideration before they were employed to work with people in a caring environment. We spoke with the interim manager who was unaware of the concern we had identified for one member of staff. . Another member of staff had left the service after a safeguarding concern had been identified. This meant the provider did not have an effective system in place to ensure people were supported by suitably recruited staff to keep them protected.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to take their prescribed medicines. We looked at the medicine administration records for four people and saw they had been completed correctly. We saw that medicines were stored as required. Staff made daily checks to ensure that the optimum temperatures of medicine storage refrigerators were maintained to ensure the contents remained safe to use.

Requires Improvement

Is the service effective?

Our findings

Staff training arrangements were not always effective. We saw that some staff had not worked within a caring environment previously or not for some time. Staff told us they received an induction when they started working at the service. During the induction, they told us, they received a combination of classroom and online training. Some people who were working for the service were doing so on a temporary to permanent basis. These staff had been recruited by an agency with a view to being employed directly by the service. We saw that during the interim period these staff were not always provided with an induction or training other than guidance on how to safely restrain people. One member of staff told us they had been working at the service for over six months but during that period had not received an induction or training. Staff we spoke with were unable to explain the Mental Capacity Act 2005 (MCA). This training was provided as part of the staff induction however three members of staff we spoke with could not remember the training or what it meant to people. This meant that people who had received the training had not understood their responsibilities associated with the Act.

The 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 living at The Boat House were unable to make their own decisions and choices. We read in their care plans that some decisions had been made in their best interest, such as for staff to be responsible for administering their medicines and personal care however the process of making best interest decisions for people had not been maintained to include recent choices made on behalf of people. This demonstrated a lack of consistency to ensure decisions made for people were always considered.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw that people who were being deprived of their liberty had been assessed by the authorising authority to ensure their restrictions were lawful. There were restrictions in place for people who were accompanied by staff at all times to protect their safety however consideration of further restrictions which affected people had not been recognised .

At our previous inspection we were concerned that people were not being supported to eat a healthy and varied diet. At our inspection on 6 January 2017 we saw that the kitchen cupboards and fridge contained more food including fruit and some vegetables. We looked at people's daily records to see what meal choices they had been provided with and saw there was still a reliance on fast food. For example we read that over a five day period people had received takeaway and fried foods for three main meals. This demonstrated that staff were not providing people with a balanced healthy diet to support their wellbeing.

People received support to maintain their physical, mental and psychological health. We saw that people received regular visits or attended appointments outside of the home with healthcare professionals such as doctors, learning disability services and social workers. On the day of our inspection one person was

accompanied by staff to attend an appointment with an optician.

Requires Improvement

Is the service caring?

Our findings

We saw that some of the information recorded in the care plans demonstrated a lack of understanding about the complex behaviours a person with a learning disability might demonstrate and read comments such as '[Name of person] has been well behaved today', which did not reflect that staff considered people's needs when referring to them.

Staff relationships with the people they supported, had improved since our last inspection. People living at The Boat House were unable to converse with us and tell us about their care so we observed how staff supported and communicated with them. We saw staff had developed their relationships with people and demonstrated more interest in them. Staff knew how to interact and engage at a level and pace suitable for each individual person. For example we saw one member of staff massaging a person's head which from their facial expression, we could see they enjoyed and helped them relax. Staff sat with people and interacted with them, either by chatting or sharing the activity that they were doing.

People looked comfortable with staff and relaxed in their company. We heard staff speaking kindly with people and saw that they responded to them with a smile. Staff spoke with knowledge about people and explained to us how they liked to spend their time. One member of staff said, "[Name of person] really enjoys a bath and it has a relaxing effect on them". People's dignity was protected by staff who spoke with them discreetly when enquiring about their personal needs and provided assistance when they saw their clothing was in disarray.

People were encouraged to develop their independence. We saw one person who had been unable to walk unaided when they first came to live in the home moved around with just occasional support from staff. Another person was being prompted to develop their everyday living skills by making their own drinks and putting their dishes into the dishwasher once they had finished their meal. We saw that people were able to sit where they wanted to and had access to their bedrooms if they wanted to spend their time there during the day. This demonstrated that people were given freedom within the home to do as they wanted.

People were encouraged and supported to maintain the relationships which were important to them. Relatives told us they could visit whenever they wanted. One relative said, "We come in regularly. Our relation seems to be doing well".

Requires Improvement

Is the service responsive?

Our findings

People received additional funding to provide support for them to take part in activities. During our inspection we saw two people were supported to go shopping and then for a pub meal but this had been planned that morning rather than following their planned activity for the day which for one person was swimming. We saw that the person had already been shopping that week and we also saw them being supported by staff in a department store a few days later. Staff told us that staffing levels could affect people's one-to-one support time. One member of staff said, "If we haven't got enough staff it means people can't go out". People's care plans contained activity plans but we saw these were not updated regularly and staff did not record an analysis of the enjoyment people had gained from the experience. We saw there was a reliance on shopping trips and local walks around the town or canal. This meant that staff were not being creative to provide people with a variety of activities which were meaningful to them.

People spent their time in the home doing what interested them. For some people this was walking around and looking out of the door and the windows. Staff told us that one person liked to look for the moon and we saw them looking into the sky. Other people enjoyed listening to their music or tearing pages from a catalogue. This meant people were able to do as they wanted when they were in the home.

People's care plans were being developed and improved to reflect their individuality and personal needs. The provider told us they had introduced a new care plan format and we saw this provided more information about the person. There were arrangements in place to review people's care however in each of the three care plans we looked at the monthly reviews recorded did not contain any detailed information, for example we saw that for each person, over a period of several months, 'no change' was indicated even though staff told us that changes had taken place. For example the use of a wheelchair lap belt had, according to the person's care plan be discontinued however staff told us this was incorrect. This meant people's care plan reviews were not accurate.

There was a complaints procedure in place. A relative we spoke with told us they would not hesitate to raise any concerns they had and said, "If I come in and see something I'm not happy about with my relation, I'm straight into the office to get it sorted out".

Inadequate

Is the service well-led?

Our findings

We have inspected this location on four separate occasions since their registration with us 18 months ago. This is because we received information of concern from the local authority and the general public. Over this timeframe, the provider has consistently been performing below the standards required. The location has had five managers over the same period, only two of whom have remained in post long enough to start the registration process with us. There is a supported living service attached to The Boat House which is registered with us separately and therefore should be run independently. We saw that, despite advising the provider previously that the homes must be operated independently, in line with their registration, this had still not been done. For example, when people living in the supported living service called for support, their buzzers were answered by staff working in the residential home. The provider has informed us during each inspection of the changes they intended to implement to improve the care and support provided to people living in home. However we have not been reassured that they had developed a consistent approach to the management of the home to drive and maintain improvement. We have continued to receive concerns raised by visiting professionals and staff regarding the care and support provided to people. When we were planning the inspection we spoke with colleagues at the local authority and were copied into emails between them and the provider. We saw that the local authority were dissatisfied with the depth of investigation the provider had conducted in response to safeguarding concerns they had raised with them. Following this inspection, we have concluded that we do not have confidence in the provider to make the necessary improvements to ensure that the service provides care that is consistently safe, effective, caring and responsive.

We saw that people's records were not always updated to reflect their care. We looked at people's daily records and saw their night care support and observations had not been completed for six days. We heard a member of staff asking a colleague if they could remember what a person had eaten the previous day as their food diary had not been completed. This meant people's care records were not written contemporaneously to ensure they provided an accurate and complete document.

People's activity plans were displayed on the wall in the communal living room however the date recorded on the plans related to three months previously and was no longer relevant. The provider had an audit programme in place designed to identify any shortfalls in the service and drive improvements. We read that all of the information documented above had been identified in the provider's own audits but no action had been taken to update the information in response to the audit findings.

We saw that people who used the service had been provided with a satisfaction survey. The survey was not in a format which supported the person's understanding and had been completed by staff. We saw that the responses to the survey from each person were the same and indicated positive responses. However it was not clear how people had been able to communicate this information to staff to validate the comments which were documented. This meant people were not supported appropriately to voice their opinions.

These are breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had left the service and there was an interim manager in post. Staff we spoke with told us this had had an effect on morale. One member of staff told us, "Morale is really low; it's been really unsettled here. We're a good team but we need consistent management". Staff also spoke of a blame culture within the home and said they did not feel supported. Staff told us they were provided with supervision sessions to discuss their performance and training needs however they told us the frequency of the supervisions could be inconsistent.