

MyLife Supported Living Limited

Burbank Mews

Inspection report

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Date of inspection visit:
05 April 2017
06 April 2017

Date of publication:
23 May 2017

Ratings

Overall rating for this service

Requires Improvement ●

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

Summary of findings

Overall summary

This inspection took place on 5 and 6 April 2017 and was announced. The provider was given 24 hours' notice.

This was the first inspection of this service. It was registered with the Care Quality Commission on 15 June 2015.

Burbank Mews is a residential service for up to 12 people with learning disabilities and/or other needs such as autism, mental health issues and physical needs. The accommodation comprises six bungalows, each with two en-suite bedrooms, a communal kitchen/dining room, living room and a garden. At the time of our inspection there were seven people living in the six bungalows.

The service did not have a registered manager as the registered manager left in November 2016. The provider's operations manager was currently managing the day to day running of 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.

During this inspection we found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because training records showed not all staff had completed training relevant to their job role. Staff had mixed views whether they had received enough training to perform their job role effectively.

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

Medicines were not always managed safely as people's prescribed creams were not always dated on opening. The temperature of the rooms where medicines were stored was not always checked regularly to ensure they were within recommended limits. A number of medicine errors had occurred in recent months which had been dealt with appropriately. Daily management checks were now in place to monitor medicines administration.

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; the policies and systems in the service did not support this practice. Further staff training on this had been arranged.

The provider's quality assurance processes had not always been effective in identifying and generating improvements for the service. An action plan was now in place and progress was being made in a number of areas.

Staff understood their safeguarding responsibilities and told us they would have no hesitation in reporting any concerns about the safety or care of people. Staff said they felt confident the operations manager would deal with safeguarding concerns appropriately.

A thorough recruitment and selection process was in place which ensured staff had the right skills and experience to support people who used the service. Identity and background checks had been completed which included references from previous employers and a Disclosure and Barring Service (DBS) check.

Risks to people's health and safety were recorded in care files. These included risk assessments about people's individual care needs. Regular planned and preventative maintenance checks and repairs were carried out and other required inspections and services such as gas safety were up to date.

People and relatives spoke positively about staff. Staff supported people to be independent and to do the things they enjoyed. People were at ease in the presence of staff.

Support plans detailed people's individual care needs and preferences. People's needs were reviewed regularly. Relatives told us they were involved in care planning.

Arrangements were in place to deal with complaints. One complaint had been received since the opening of the service; this had been dealt with appropriately and to the satisfaction of the person concerned.

Feedback from people who used the service and their relatives was sought regularly. A formal satisfaction survey was due to be launched in the coming weeks.

The provider's operations manager was currently managing the day to day running of the service and had been since 4 January 2017. A new service manager, who was due to apply to the Care Quality Commission to become the registered manager, was due to start by the end of April 2017.

The operations manager and chief executive officer said it had been challenging opening a new service but they felt things were improving now. Staff also said it had been challenging but spoke positively about the improvements the operations manager had made.

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.

Medicines were not always managed safely.

People and relatives we spoke with felt the service was safe.

Accidents and incidents were recorded and investigated appropriately.

Thorough background checks had been carried out to ensure staff were suitable to care for vulnerable adults.

Is the service effective?

Requires Improvement ●

The service was not always effective.

Not all staff had completed training the provider deemed mandatory.

Staff had not received regular supervisions.

People had input from external health care professionals where required.

People were supported to have enough to eat and drink.

Is the service caring?

Good ●

The service was caring.

People and relatives spoke positively about staff.

People received support to do the things they enjoyed.

People's independence was promoted wherever possible.

People were comfortable in the presence of staff.

Is the service responsive?

Good ●

The service was responsive.

Support plans contained clear information about people's individual care needs.

People's bedrooms contained personal items important to them.

Feedback from people and relatives was sought regularly.

People took part in a range of activities.

Is the service well-led?

The service was not always well-led.

The provider's quality monitoring system had not always been effective in identifying areas for improvement.

The service did not have a registered manager, although a service manager had recently been appointed who was to apply to become the registered manager.

Staff said they had enough opportunities to provide feedback on the service.

Staff said the service had improved in the past few months due to management changes.

Requires Improvement ●

Burbank Mews

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 comprehensive inspection took place on 5 and 6 April 2017 and was announced. The provider was given 24 hours' notice because the service is for younger adults who are sometimes out during the day, so we needed to be sure someone would be in. The inspection was carried out by one adult social care inspector.

Before the inspection, we looked at the information we held about the home. This included notifications of events that happened in the home that the registered provider is required to tell us about. We also contacted the local authority commissioners for the service, the local authority safeguarding team, the clinical commissioning group (CCG) and the local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Some of the people who used the service had complex needs which limited their communication. This meant they could not always tell us their views of the service, so we asked relatives for their views. We spoke with five relatives who were visiting the service during the inspection and two relatives on the telephone after the inspection.

During the visit we spent time with four people who were using the service. We spoke with the operations manager (who was currently managing the service), the chief executive officer, two senior support workers, eight support workers and three health professionals who visited the service during our inspection.

We viewed a range of care records and other records relating to how the service was managed. These included the care records for two people, the medicines records for four people and recruitment files for four staff.

Is the service safe?

Our findings

Medicines were stored securely in each bungalow but the temperature of the rooms where medicines were stored were not always checked daily to ensure they were within recommended limits. For example, in one bungalow staff told us and records confirmed the temperature of the room where medicines were stored had not been checked for the previous five days. This meant we could not be sure all medicines were kept at a temperature that was within recommended limits for safe storage, which may have impacted upon the effectiveness of the medicine.

Prescribed creams were not dated on opening which meant we could not be sure people received their creams when they were safe to use. However, prescribed creams were recorded when administered on people's medicines administration records and body maps were in place. This meant people received their prescribed creams when they needed them, in line with the instructions on their prescriptions.

13 safeguarding incidents had been recorded since the service opened, the majority of which related to medicine errors. Staff were given additional medicines administration training and were observed by the management team so their competency in this area could be assessed. New protocols were also put in place to minimise the risk of future errors. The operations manager told us this was an ongoing area for improvement and they would continue monitoring this through daily checks. Where staff had made more than one medicine error appropriate disciplinary action had been taken.

The four medicines administration records (MARs) we checked during our inspection had all been completed correctly. The operations manager told us a medicine error had been identified from the previous day. This was being investigated appropriately.

People and relatives we spoke with felt the service was safe. One relative said, "[Family member] is safe and secure here." Staff also said the service was safe. A staff member said, "Yes people are safe here. Staff report things straight away to [team leader] and [operations manager]. Staff know when the people we support are getting agitated. They read the signs and divert people accordingly."

People's support plans contained risk assessments specific to the individual for events such as travel, activities, personal care and using sharp knives during meal preparation. Risk assessments included control measures to reduce the risks which meant staff had clear information about risks and the action they needed to take to minimise them.

Regular planned and preventative maintenance checks and repairs were carried out. These included daily, weekly, quarterly, and annual checks on the premises and equipment, such as fire safety equipment and water temperatures. Other required inspections and services included gas safety and portable appliance testing. The records of these checks were up to date.

Accidents and incidents were recorded accurately and analysed regularly in relation to date, time and location. This information was reviewed by the board monthly to look for trends. Although no trends had

been identified recently, records showed appropriate action had been taken by staff.

We checked the fire safety arrangements at the service. Each person had a personal emergency evacuation plan (PEEP). A PEEP is a bespoke 'escape plan' for individuals who may not be able to reach a place of safety unaided or within a satisfactory period of time in the event of an emergency. These contained details about the specific needs each individual had, which meant people could be evacuated safely in the event of a fire.

Recruitment practices for new staff members were robust and included an application form and interview, references from previous employers, identification checks and checks with the disclosure and barring service (DBS) before they started work. DBS checks help employers make safer recruitment decisions by preventing unsuitable people from working with vulnerable people. This meant there were adequate checks in place to ensure staff were suitable to work with vulnerable people.

Safeguarding referrals had been made and investigated appropriately. A log of all concerns was kept up to date and staff had access to relevant procedures and guidance. Appropriate action had been taken following safeguarding incidents. Staff knew the signs to look out for such as changes in people's demeanour or appetite. 'Say no to abuse' posters were on display in each bungalow and records confirmed safeguarding was a standing agenda item at staff supervisions and meetings.

Staff told us they had confidence in the management team to deal with safeguarding concerns promptly and appropriately. A staff member said, "[Operations manager] is very open and truthful and reports everything."

The provider employed 48 staff. Staff rotas for the previous week were as described by the operations manager. People who used the service had been assessed as needing high levels of staff support to keep them safe. The staffing levels were different in each bungalow depending on people's assessed care needs. For example, one person needed support from two staff members 24 hours a day. Relatives and staff we spoke with said there were enough staff on duty.

The provider used agency staff to cover shifts but this had reduced during recent months. The operations manager told us how they had recruited more staff recently including a new service manager (who will apply to the Care Quality Commission to become the registered manager) and a care practice lead. One staff member told us, "Staff are more settled now as more staff have been recruited."

We visited four bungalows which were spacious, nicely furnished and clean.

Is the service effective?

Our findings

Training records showed not all staff had completed training the provider deemed mandatory. For example, out of 48 staff 16 had not completed safeguarding vulnerable adults training, 16 staff had not completed mental capacity training and 13 had not completed deprivation of liberty training since starting employment at the service. Other training the provider did not deem to be mandatory had not been completed by all staff. For example 30 staff had not completed autism awareness training; six people who used the service had autism. When we spoke with the operations manager about this they acknowledged this was an area for improvement and would arrange autism awareness training as a priority.

Staff we spoke with had a limited understanding of mental capacity and deprivation of liberty safeguards and what that meant for the people they supported in terms of restrictive practices. This meant we could not be sure staff were trained to complete their job role effectively.

One staff member told us, "We need more training specific to the needs of the individual as the people we support have complex needs."

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed staff had not received regular supervisions in 2016, in line with the provider's policy which stated staff should receive six supervisions a year. The majority of staff had received two or three supervisions in 2016 instead of six. The purpose of supervision was to promote best practice and offer staff support.

When we spoke to the operations manager they said a significant amount of additional training had been arranged for the coming months and supervisions were now "back on track." The operations manager told us, "Staff have completed online mental capacity training but they could benefit from face to face training so they understand the principles. This is arranged for April 2017." We noted that a recent audit identified the need for additional staff training in this area.

Supervision records for 2017 so far showed that staff were receiving supervisions in line with the provider's policy. A staff member said, "I've had about two supervisions in six months. These are very useful as we can give our views and get feedback on our performance." Another staff member told us they had only had one supervision in nearly a year but supervisions were now planned and happening more regularly since the operations manager had been in post.

A staff member said, "Previously there was no guidance or support and I felt lost, but [operations manager] has improved that." Another staff member told us, "I feel supported by the management team now. We now have regular meetings and we see the management team."

Staff had mixed views about whether they had received enough training. Some staff we spoke with said they

felt confident dealing with people whose behaviour may challenge themselves or others, due to the training they had received. One staff member told us, "We had training how to deal with one person's behaviour that could be challenging and incidents reduced dramatically after we supported them to use coping strategies."

Other comments from staff included, "We can ask if we want extra training and management will organise this" and "There is more training in place now than there was before. We've had loads of really good training especially SCIP" (SCIP stands for strategies for crisis intervention prevention).

The operations manager had arranged for staff from the community learning disability team to facilitate learning disability awareness training sessions for staff. These took place in February 2017. A health professional who was visiting the service during our inspection and who had facilitated this training said, "Staff engaged well and made good use of the training. There were lots of useful discussions."

Staff told us they received a three week induction during which they completed mandatory training and shadowed experienced staff. One staff member who was new to the organisation said, "It was the best induction I've ever had. This is the best company I've worked for yet, it's absolutely unbelievable. The staff are so impressive because they think outside the box."

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 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 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. All seven people who used the service had an appropriate DoLS in place. Care records we viewed contained mental capacity assessments and best interest decisions on issues such as physical interventions and specific activities in the community.

People were encouraged to maintain a balanced diet and to have enough to eat and drink. People's food and fluid intake was recorded where appropriate and people's weight was checked regularly for those who needed it. Further action was taken where appropriate after discussion with relatives and professionals. One fluid chart we viewed lacked detail in relation to guidance for staff on action to be taken if the total was not reached. We discussed this with the operations manager and they said they would contact the person's GP to discuss this.

Records showed people were supported to maintain their physical and mental health needs whenever this was required. For example people attended appointments with a dentist, dietician and speech and language therapist. Records of these appointments were kept in a diary and in people's support plans.

Is the service caring?

Our findings

People and relatives spoke positively about staff. One person told us, "I'm very happy here. The staff are excellent." Another person said, "The staff treat me right and help me make food I like." A relative said, "[Family member] is really happy here. I can see the change in them. It's made such a difference them being here." A second relative told us, "[Family member] is more confident now, there's a marked improvement." A third relative said, "[Family member] seems quite happy. Staff seem to care."

There were positive relationships between people and staff. People were smiling and their body language indicated they were at ease in the company of staff. There was a welcoming and homely atmosphere. Staff spoke to people kindly and calmly and explained what they were doing before providing care.

Staff supported people to do the things they enjoyed and also encouraged independence with daily living. For example, going out for meals and making their own breakfast. A staff member said, "We try to give people choices and control of their lives." Another staff member told us, "We try to encourage the people we support to do tasks which improve their life skills. We also support people to improve their communication skills. We know the people we support well."

Staff we spoke with said they enjoyed working at Burbank Mews. A staff member said, "We've got a good team here now. We support each other to give clients the best support we can so they can live the lives they want."

We observed staff spoke with people in a kind, caring and respectful way, taking time to listen to people and understand what they were communicating. People had communication support plans in place. The operations manager told us they were looking at developing these further with more input from learning disability and speech and language teams. Staff were attentive to people's feelings and reassured people if they were anxious or unsure. During this visit we saw lots of interaction between staff and people, and in one bungalow with several members of one person's family.

Staff knew people and their families well and exactly what support people needed in various situations. For example, staff told us how one person liked to be out and about and to have a set daily routine as this reduced their anxiety.

People were treated in a respectful and dignified way. People who needed physical assistance to eat and drink were provided with this in a dignified way.

Information about advocacy services was not always readily available, as it was in some bungalows but not others. An advocate is someone who represents and acts on a person's behalf, and helps them make decisions. We discussed this with the operations manager who said they would rectify this immediately. One person who used the service had an advocate; other people had family members to advocate on their behalf.

Each person who used the service was given a 'service user guide' (an information booklet that people received on admission) which contained information about the service. This included the service's statement of purpose and how to make a complaint.

Is the service responsive?

Our findings

Each person who used the service had a support plan in place to address their needs in all aspects of their lives such as personal care, physical health and social needs. Support plans were person-centred, taking into account people's individual needs and preferences. Staff were able to review this specific information about how to meet people's needs. We read information entitled, 'the top six things important to me,' 'my daily routine,' 'people important to me' and 'things I am good at.' This meant staff were able to deliver care in a way that met the person's personality, routine and preferences.

Records we viewed contained a 'disability distress assessment tool.' These contained good summaries of signs and behaviours when a person was content or distressed and was a good resource for staff to refer to.

People had been included in their own care planning, where they were able. Some people had limited involvement in their care planning because they could not always communicate their needs fully. Relatives told us they were involved in care planning and they attended regular meetings to review their relatives' needs. A relative told us, "We have regular meetings to go through all the details relating to [family member's] care. Every couple of weeks we get together to discuss their care, they are really good. If we needed to change anything I would contact them. I read every word to ensure it's correct. The care plans are all about [family member] and their likes and dislikes."

Support plans were evaluated frequently and regular reviews took place which involved people who used the service where possible, relatives and other professionals, particularly if a person's needs changed. This meant there was a system in place to monitor people's care and ensure care and support continually met people's needs.

Each person also had a 'hospital passport' which was based on a 'traffic light' system. For example red related to 'things you must know about me,' amber related to 'things important to me' and green related to 'my likes and dislikes.' Hospital passports we viewed contained a good overview of the person's needs. This document could then be taken to hospital if people needed care in this setting, to ensure all professionals were aware of their individual needs.

People's bedrooms were personalised with pictures, posters and items important to them. They were encouraged to pursue their hobbies and interests. For example, two people liked to watch a local football team play so staff supported them to attend matches. Another person was supported to go to the cinema which they previously had been unable to do.

Activities were mainly arranged on an individual basis although people socialised with each other where appropriate. Activities included discos, going to a nearby bistro for lunch, outings to the seaside and shopping trips. Staff told us how they had arranged a party bus with music and non-alcoholic cocktails for one person's birthday which the person had really enjoyed.

The provider had a complaints policy which was available to people, relatives and stakeholders. Relatives

we spoke with said they had no concerns but would speak to staff if they did. One complaint had been received in the last 12 months which had been dealt with appropriately, in line with the provider's policy and to the satisfaction of the person concerned.

People views were mainly sought on an informal basis although the operations manager told us more formal arrangements were being set up. For example, three 'PEOPLE@My Life' (personal, empowering, opportunities, positivity, living and engagement) meetings had been arranged recently but nobody had attended, so staff were thinking of other ways to obtain people's feedback. The operations manager said they would speak to people individually and ask them how they preferred to give their feedback. The team leader told us, "It's important to pick the right time to get feedback from people." Feedback from relatives was sought at care planning and review meetings which happened regularly. A formal satisfaction survey was due to be carried out in the coming weeks.

Is the service well-led?

Our findings

The provider had a quality monitoring and audit system in place to review areas such as support plans, medicines, safeguarding incidents and complaints. Before the operations manager took over the day to day management of the service in January 2017 audits had not happened regularly. When they had been carried out they had not been effective in identifying or generating improvements to the service. A service quality audit in April 2016 identified that the registered manager needed to ensure audits took place regularly and actions resulting from audits were completed in a timely manner. We saw this had not happened until January 2017.

Three out of four staff files we viewed did not have complete records relating to induction.

Whilst recent audits identified the areas for improvement we found during this inspection the governance procedures need to be embedded to ensure improvements can be sustained over time. A service improvement plan was now in place which identified what actions were necessary, the lead staff responsible and target dates for completion.

The operations manager sent a monthly operational report for the provider's board to consider. This included all aspects of service delivery such as staffing issues, training needs and accidents. The chief executive officer visited the service regularly and was known by people who used the service and staff.

The service did not have a registered manager as the previous registered manager left in November 2016. The provider's operations manager was currently managing the day to day running of the service and had been since 4 January 2017. A new service manager, who is due to apply to the Care Quality Commission to become the registered manager, was due to start by the end of April 2017. The operations manager and team leader assisted us throughout the inspection.

The chief executive officer and operations manager acknowledged that providing consistent staff teams had been challenging and there had been "teething problems" opening a new service, but things were improving now. When the previous registered manager left the operations manager relocated to the area so they could manage Burbank Mews on a day to day basis while a new service manager was recruited. The operations manager said, "I'm committed to making this service work for the people who live here. I'm really proud of the staff team."

Staff we spoke with said things had been challenging but the service had improved in recent months. A staff member told us, "The service has improved since the arrival of the new management team. They've made progress quickly and things are going in the right direction now." A second staff member said, "Burbank Mews is really good now. [Operations manager] has made a massive difference. Things have really improved." A third staff member commented, "Everything's improved in the last few months. Support plans are much more detailed and person-centred and paperwork is easier for staff to understand."

Staff meetings had been held regularly since December 2016 but not before then. Minutes of staff meetings

showed that service improvement, staff training and supervisions, medicines and support plans had been discussed. Minutes of staff meetings were available to all staff so staff who could not attend could read them at a later date. Staff told us they had enough opportunities to provide feedback about the service, but this had not always been acted on in the past although it was getting better. One staff member told us, "I feel I can talk to the management team about everything. Things are getting done now."

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 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that staff received appropriate training to perform their job role effectively. Regulation 18 (2) (a)