The Centre For Better Health Ltd

Psychiatric Rehabilitation Association - 44 & 60 Chesterfield Gardens

Inspection report

44 & 60 Chesterfield Gardens
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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?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We inspected this service on 30 November 2016. The inspection was unannounced. Psychiatric Rehabilitation Association is a care home registered for a maximum of seven adults who have mental health needs. At the time of our inspection there were five people living at the service. The service is located in two large houses on the same street, 44 & 60 Chesterfield Gardens. Each house has two floors with access to a back garden.

We previously inspected the service on 30 August 2013 and the service was found to be meeting the standards inspected.

Whilst there was a registered manager at the service, the registered manager was away from work so there were temporary management arrangements in place. One staff member was temporarily promoted to supervise the home. The provider had also appointed a temporary service manager the week of the inspection who would oversee the running of the home, though was not based at 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.

People living at the service told us they felt safe. People told us they found the staff caring and we witnessed kind interactions between staff and people living at the service on the day of the inspection.

Staff recruitment was not always safe as the provider could not evidence references had been applied for.

Although there were risk assessments in place which were updated regularly, they did not cover all the risks identified in the care plans and care records. Also, we found some were generic in nature so did not offer specific advise to staff in managing risks identified. Care plans were in place and had been updated regularly.

Staff supervision, appraisal and training took place.

We found medicines were stored and administered safely. However, not all staff were aware of the side effects of medicines.

The service was clean throughout and food was labelled and sealed hygienically. Accidents and incidents were recorded but we could not always evidence learning had taken place as a result, and was shared with the staff team.

We checked the system for managing people's money. Receipts were available to show expenditure and

there were spot checks of funds against records. There was a lack of evidence to explain the authority the service had to manage people's money.

We noted one practice by the registered manager that lacked understanding of consent in relation to one person living at the service.

Some people living at the service told us they thought there was not always enough staff to support them. The provider told us agency staff were to be employed to fill any vacancies on the rota following the inspection, and they would review how staff were deployed across the houses.

Food was plentiful and people had an opportunity to choose the menu. People prepared their own breakfast and lunch if they were able, and staff cooked the evening meal.

People had some opportunities to be involved in their care through key worker sessions, and we saw that outings took place that had been chosen by people living at the service.

Fire drills took place regularly and there were checks of the premises for health and safety risks. There were some minor repairs required to the building and the décor was dated in some areas. Some furniture needed replacing in the communal areas.

We found breaches of the regulations in relation to staff recruitment, consent, risk assessments and governance of the service.

We have also made a recommendation in relation to personalisation of care records.

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?

Requires Improvement

The service was not always safe. There were not risk assessments in place for all risks identified and actions to mitigate risks were not always personalised.

The provider could not evidence staff were safely recruited.

Medicines were stored and administered safely.

The majority of people living at the service told us they felt safe living there.

Is the service effective?

Requires Improvement

The service was not always effective. Consent was not always evidenced in the managing of people's money.

One person's personal item was taken from them as a form of control.

People had access to key training, supervision and appraisal.

People using the service were supported to attend health appointments

Is the service caring?

Good

The service was caring. People living at the service told us staff were caring and we observed good interactions between staff and people using the service.

People were treated with dignity and respect and their cultural and spiritual needs were met.

Is the service responsive?

Requires Improvement

The service was not always responsive. There was not an effective complaints process in place for people living at the service.

Care plans were in place and updated regularly.

People could choose the outings that took place.

Is the service well-led?

Requires Improvement

The service was not always well led. Management audits were not robust enough to highlight areas for further improvement.

Staff did not feel they could contribute their views to the running of the service.

Psychiatric Rehabilitation Association - 44 & 60 Chesterfield Gardens

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 took place on 30 November 2016 and was unannounced. The inspection team comprised of two adult social care inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we looked at the information we held about the service including notifications they had sent us and information from the local authority.

During the visit, we spoke with two members of staff. We also spoke with one health and social care professional who was visiting the service on the day of the inspection.

We looked at care records for four people using the service and we talked with four people living at the service. We checked medicines storage and records related to medicines.

We looked around the premises including looking at four bedrooms occupied by people living at the service. We looked at records relating to food hygiene and maintenance of the service. We reviewed training records for the staff team and supervision records for five members of care staff. We also looked at the recruitment process for three of the staff.

After the visit we spoke with two relatives of people who use the service and another two health and social care professionals. We also spoke with the Director of the organisation.

Requires Improvement

Is the service safe?

Our findings

People told us they felt their belongings were safe. Three people out of four told us they felt safe. One person told us they felt safe "kind of sometimes". Their concern related to a person they shared accommodation with. We discussed this with the Director who undertook to review people's experience of sharing accommodation with other individuals.

We looked at the staff rota. On the day of the inspection there was one staff member short in relation to the rota. We noted that staff spent the majority of the day at one of the houses whilst the majority of the people currently living at the service were based at the other house.

We asked people's views on staffing and whether there were enough staff to meet their needs. Two people thought there were not enough staff around. They said there's "No staff in the building in the day" and "Only one or two sometimes there needs to be a bit more.'' A third person told us "Normally I just walk over there [to No 44]." One person told us they thought there was enough staff.

We discussed the deployment of staff across the houses with staff on duty that day, and the Director after the inspection visit. We were told that staff moved between the houses as necessary during the day. There was a facility to sleep-in at one of the locations but not at the other. The Director noted comments from people living at the service and observations by inspectors during the visit. He undertook to review the staffing arrangements and has confirmed that staff are now spending a significant amount of time moving between the houses. The Director also reported that all shifts on the rota were being covered by permanent or agency staff and that he was confident that there was sufficient staff on duty to meet peoples' needs.

We checked recruitment records for staff following our inspection visit as records were held at head office. The Director could provide completed application forms, evidence of the right to work in the UK and evidence that Disclosure and Barring Service checks had taken place, but he was unable to locate references. The person responsible for recruitment within the organisation no longer worked for the service, so he was unable to confirm references had been pursued. This was of concern as the provider has to satisfy himself that staff recruited are considered safe to work with vulnerable people.

We concluded that the above concern was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessment were on care records, some related to generic situations and these were less personalised, and other risk assessments related to specific actions, for example, going to the shops alone. Whilst these were more personalised we noted overall there were some areas that were not covered by any risk assessment, even though these risks were noted elsewhere in their care records. For example, one person was at risk of sexual abuse and self-harm, but there was no risk assessment covering these areas. We also found two people who did not have a risk assessment related to their mental health or medicines, and one person's fire risk assessment did not note they smoked in their bedroom.

We noted that the evening meal was prepared at one of the houses. If people did not want to eat at No 44 the meal was taken to No 60 for them to eat in their own home. We discussed this with the staff who told us that they regularly carried hot food from one house to another.

There was no evidence to show the provider had risk assessed staff practices to sleep at one house and not the other, and to regularly cook hot food at one house and transport it to the other.

The above concern was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the Director has prioritised risk assessments for people living at the service and this was confirmed by the health and social care professional we spoke with. Also he agreed to evaluate the risks attached to specific staff practices.

Staff were able to tell us about the types of abuse that can occur and what they would do if they had any safeguarding concerns. We were unable to locate the safeguarding folder on the day of the inspection, so discussed this with the Director following the inspection visit. He confirmed that safeguarding issues had been dealt with appropriately and there remained an outstanding safeguarding investigation at the time of the inspection visit. CQC had been made aware of the current safeguarding concern. Staff knew about whistleblowing and what to do if they had concerns. The Director told us there was signage going up in the building to alert people and staff as to how to pass on any concerns they may have.

Medicines were stored safely. Records were up to date, were completed appropriately, and stocks tallied with records. People knew why they took medicines and what medicines they were on. We noted that not all staff were able to tell us the side effects of medicines the people at the service took, and one person had a health check each morning for a specific condition, but the staff member who checked it was unable to tell us what they would do if the limit was above or below normal. The Director undertook to discuss this with staff to ensure they were familiar with the medicine the person took and what remedial action to take if the reading was out of normal range.

The service was clean throughout. The provider employed staff whose role was to clean the service, and additional cleaning was undertaken by care staff. There were infection controls in place. Aprons and gloves were available, and different chopping boards were used for preparation of food to minimise the spread of infection. The fridges were clean and food was sealed and labelled. We noted one item of food that was out of date. This was thrown away and the staff undertook to check the expiry dates for all food following the inspection.

We noted the temperature for the fridge was routinely above 5 degrees Celsius. We spoke with the Director who told us a new fridge had been purchased as had a new temperature gauge, as he believed this had been faulty. Staff now had guidance as to the action to take if the fridge was above 5 degrees. The mops at one location were old and difficult to keep clean. The Director undertook to purchase new mops following the inspection.

We checked receipts against records for people's money being held by the service and these tallied, and we could also see that there was a monthly check of people's finances by senior managers.

We looked at accident and incident folders. Accidents were recorded but there was no management oversight to confirm they had been noted by the manager. Incident logs were completed and on occasion information was passed to other staff either by the communication book or people signed to say they had

read the incident log. There was not always evidence of learning from incidents. For example, when the clothes dryer overheated it was not clear if there were any actions that could be taken to minimise it happening again. The dryer was in a very small room which could become very hot and it was not stated that people needed to clean the filter regularly.

There were minor repairs outstanding as the lock to the cupboard containing cleaning products in No 44 was not effective and the bathroom door in the same house was not closing properly. Following the inspection the Director reported these had been repaired.

We noted the service had not been decorated for some time and there was damage to the walls in both living rooms. We also noted the chair in No 44 and the sofa in No 60 were uncomfortable to sit on due to damage or wear and tear. The Director has confirmed these have been replaced following the inspection.

Window restrictors were fitted on upstairs windows and were checked weekly. As part of the inspection visit we checked these were in place and we noted on one window the restrictor had been overridden and so one window was not restricted. The staff corrected the fault and agreed to check the person was not overriding this facility. Staff agreed to take more permanent action if required to ensure the window opened only to within safe limits.

Gas and electricity (including portable appliance testing) checks had been undertaken in the last 12 months. Electrical checks took place across both houses and fire equipment had been serviced and maintained in the last 12 months. A fire risk assessment had been completed in July 2016 for both houses. Fire checks of the building took place weekly and we could see from care records that each person had a personalised fire plan which staff discussed with people monthly.

Requires Improvement

Is the service effective?

Our findings

Two people told us they thought the staff had the skills and knowledge to do the role of caring. One person told us "To a point they understand me." Another person told us "They don't do anything", but wouldn't be drawn on what tasks they wanted done, that weren't completed by staff.

We were concerned to note in the staff communication book an entry that was undated, but took place between 18 and 21 June 2016. The registered manager referred to taking an action that restricted a person's access to their belongings and through this communication conveyed to staff this was an acceptable working practice.

We noted that five people's money was held by the service and there was not always evidence that this arrangement had been formally agreed by the person whose money it was. For example, one person's family managed their finances and whilst there may be documentation to legitimise this practice, there was no evidence of this on their care records. We discussed this with the Director who acknowledged that they had 'inherited' systems when people moved in, but had not requested the relevant paperwork. This was of concern as one person refused to sign their care documentation which noted they would be rationed money daily, and without the relevant paperwork the provider was curbing their access to money.

We concluded that these concerns were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Director undertook to review people's financial arrangements and ensure relevant paperwork was in place following the inspection.

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. One person required a DoLS to be in place and there was evidence a renewal had been applied for and the person was assessed on the day of the inspection.

Training records showed that staff had undertaken training in the majority of key areas required to carry out their caring role. These included safeguarding adults, food safety, first aid, manual handling, challenging behaviour, medicines administration and health and safety at work. Four out of five people had received training in the MCA. None of the five people had been provided with generic training in working with people

with mental health needs.

Staff were supervised regularly. They told us the agenda was set by the registered manager and it was an opportunity for them to get updates on information required for the running of the service. Staff had received an appraisal in 2015 and were due to have their yearly appraisal at the time of the inspection.

Where people were able, they prepared their own breakfast and lunch and staff cooked the evening meal. There was a range of food available at both houses. People said "Yes" they were "given a choice. We decide what we would like for dinner." We were also told "we get snacks, crisps, biscuits and healthy snacks". One person liked to get their food from a particular shop so they were supported by staff to buy their food there.

We noted that people were referred to a range of health services and they had access to health professionals as required including effective links with the local mental health services. Health and social care professionals had no concerns regarding the care provided at the service and told us the staff worked with them to support people's good health. People living at the service were weighed monthly and people were supported to manage their health conditions through a mixture of health appointments, medicines and lifestyle choices.

Good

Is the service caring?

Our findings

We saw staff were kind and caring, and people confirmed staff were kind to them. One person told us staff are "very patient and kind".

People told us they could have visitors to the house until 10pm, and they were encouraged by staff to keep contact with friends and family. People told us "Yes friends come here" and "Family, sometimes my mother". Another person told us "I have decided that I don't want any visitors." One person told us "I do go to church on Sundays. I go on my own." Staff supported other people to church and places of worship.

We noted that two people living at the service were spending significant amounts of money on dry cleaning for everyday items that could have been washed and ironed at the service. Staff told us this was a usual long standing practice for these two people living there. Following the inspection the Director told us this practice had been reviewed and dry cleaning would be an exception rather than being routinely used, as staff could wash and dry these items of clothing free of charge.

People told us their cultural needs around food were met. One person ate vegetarian food another preferred Caribbean food. One person was supported to attend the local Greek restaurant as they liked and were familiar with this style of cooking.

Care records were signed by people using the service or if they weren't it was noted people had refused to sign. People did not recall signing care records, but they told us "They [staff] do listen to me."

People also told us that the staff did give them privacy and treated them with respect. We asked people did the service feel like home. One person told us "For now, I'm happy with what it is," and another person said "'Yes, I don't want to move on. I want to stay here. It's the best place for me." Staff told us they treated people with respect by "not getting in their faces" and "not telling people what to do".

People were encouraged to be independent. There were some sessions undertaken by staff in supporting people to cook, and we could see that people where possible, cleaned their own rooms. However we noted there was no clothes dryer in No 60 and the washing machine in No 60 was not working and had been faulty for some months. This meant people were carrying their washing up the road to No 44 to use the washing machine there. This did not afford people privacy or respect. One person had complained about the broken washing machine, but this hadn't been repaired at the time of the inspection. The Director undertook to replace the washing machine following the inspection, and review if the provider could purchase a second dryer for No 60.

There had been six meetings for residents to discuss their views in the last 12 months. Agenda items included menu choice and group activities. People were unsure about the meetings and attendance was not high. They told us "I did hear that they do have them but I don't see what use they have." And "I haven't been to one since I've been here." A third person told us "I think we did have one."

Requires Improvement

Is the service responsive?

Our findings

Care plans were up to date and covered a range of areas including medicines, physical health, self-care activities, social relationships and leisure. Some aspects of care records were personalised, but sections for people's views were not always filled in and we noted that in the section where side effects of medicines were to be noted, it routinely stated none. We found some care records related to health and safety issues were also not personalised. Files were not easy to navigate as they were full of historical documents.

Key working sessions took place monthly and these were recorded. It provided an opportunity for staff to catch up with people with a view to progressing life goals. The document structure was set. As a result, staff told us it did not elicit much personalised information.

We recommend care plans and key working notes are reviewed to ensure they are personalised to each individual.

People told us "yes" staff did give them sufficient time to make a decision about their care needs. This was positive as it meant staff worked with people at a pace that suited them.

We asked people how they spent their days. Some people told us "I stay in [my] room or go to shops" and "I don't do anything just watch TV." Another person told us "Art, done it at 44, maths at 44. I go to the park with staff and we have an ice-cream."

We could see that there had been trips to the seaside during the summer and there was a lunch out once a week that people joined in with if they chose. Some people had more regular activities they enjoyed. One person attended a day centre regularly; another person went to the gym and was volunteering locally. There were limited activities at the service, although there were activities planned for the Christmas period. The majority of people were independent and went out as they pleased to meet family, friends or go to the local shops.

Relatives told us they had had no cause for complaint and were happy with the care provided to their family member. People told us a range of answers when asked if they had made a complaint or knew how to. One person said "I like the one who introduced you to me she's the only one I would talk to." Another person said 'Yes. "I think I have. It's been dealt with. I report maintenance stuff to the staff and make sure everything is secured." A third person said "No", they wouldn't complain as they didn't "want to get anyone in trouble".

Staff were not aware of a complaints book and told us they had not received any concerns or complaints. We discussed this with them and noted that they had told us one person had complained that the washing machine did not work at No 60. They had not considered this a formal complaint and so it was not logged. They had passed on the information regarding the broken washing machine but at the time of the inspection it had not been fixed. We found a complaints book with the last complaint logged in 2014. This indicated that staff were not familiar with or knew how to deal effectively with complaints.

Since the inspection a central complaints book has been put in place, and the Director has discussed the importance of identifying, acting on and recording complaints with staff.

Requires Improvement

Is the service well-led?

Our findings

Some aspects of the service were well led. For example, relatives told us they were happy with care provided and their family member had improved since living at the service. This was confirmed by health and social care professionals we spoke with and by records at the service.

There were systems in place to provide regular supervision to staff. Training had taken place, the premises were clean, and the building safely maintained. Key worker sessions took place monthly and there was a list in each file of tasks the staff should undertake in the coming months.

Medicines were well managed and in the main, people told us they were happy living at the service. We saw regular quarterly quality assurance visits took place at the service by senior managers. Senior managers checked the safety of the building, cleanliness and talked with members of staff and usually three people living at the service. But the records lacked detail and there wasn't an action plan with dates of completion as a result. For example it was not possible to evidence that specific care records were reviewed or when the project to update care records was due to finish.

There were finance audits taking place on a monthly basis by senior manager. These were useful as they checked money stored against receipts, but senior managers did not question the authority of the service to manage people's money nor enquire what people's money was spent on. This lack of inquisitiveness was of concern as senior management oversight can provide a quality assurance check on the service to ensure good standards of care are achieved and maintained. The audits had not picked up the lack of paperwork to neither justify managing people's money nor the repeated expenditure on dry-cleaning for two people which could appear excessive.

There were other areas in which the service was not so well managed. We noted the lack of notifications to CQC for two incidents involving the police in the last 12 months.

This was a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009.

Whilst staff meetings took place, staff told us they were not confident to give their views as the meetings did not provide the opportunity for them to do so. We noted a survey of residents' views had been undertaken in October and November 2016. Results we saw were positive, but the questionnaires had been completed by staff on behalf of the people living at the service, even when people were able to write themselves and so were not anonymised.

The registered manager displayed a lack of awareness of people's rights as evidenced by the entry in the communication book in June 2016 in which a person's personal item was withheld from them as a punishment for an action they had taken. This was of concern as this type of action within a staff team can create an environment in which people are at risk of abuse.

We concluded that the above concerns were a breach of Regulation 17 of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

We found the Director open and transparent in our discussions with him about the service as part of the inspection process.

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 Registration Regulations 2009 Notifications of other incidents The provider did not notify the Care Quality Commission of incidents involving the police. Regulation 18 (2)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider could not evidence they had permission from people to manage their money. The provider could not evidence they had permission to remove a personal belonging from a person. Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure the safe care and treatment of service users as risk assessments did not cover all identified risks and provide guidance for staff to mitigate the risks. Regulation 12 (1)(2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not ensure there were sufficient systems and processes in place to evaluate the quality of the service. The provider did not keep adequate records related to the

employment of staff at the service. Regulation 17 (1)(2)(a)(b)(d)(f)