Boulevard Care Limited

Boulevard House

Inspection report

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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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Boulevard House is a residential care home providing accommodation and personal care to up to 15 people. The service provides support to people with a learning disability. The accommodation comprises of a bungalow with 3 bedrooms and a main house with 12 bedrooms. At the time of our inspection there were 11 people using the service.

People's experience of using this service and what we found

Right Support
Risks were not always assessed or managed to ensure staff had the appropriate guidance to keep people safe. The use of restrictive interventions had not been risk assessed so we could not be assured people would be kept safe if restrictive practice was used. Restrictive interventions are interventions that restrict or limit what people can do or where they can go; they can also be used to subdue or control distressed reactions. Restrictive intervention includes physical restraint which is any direct physical contact where the intention is to prevent, restrict, or subdue movement of the body, or part of the body of another person.

Positive behaviour support plans did not give enough information to staff on whether restrictive interventions could be used when people were distressed. Staff told us they had training in prevention and management of violence and aggression but did not need to use it.

Improvements had been made to how incidents were recorded and responded to. Further action was required to ensure documentation and management oversight was consistently completed to ensure it was clear what strategies or interventions had been used when people were distressed.

We could not be assured body maps were effectively used to document and illustrate visible signs of harm and physical injuries. Body maps that had been created, were seen to not be reviewed to track progress and ensure the appropriate treatment was being given.

Further improvements were needed to ensure medicines were managed and administered safely. There had been a reduction in the use of prescribed 'as required' (PRN) medicines, used when people were distressed.

People were supported to have maximum choice and control of their lives and staff supported them in the

least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. However, Deprivation of Liberty Safeguards and the key requirements of the Mental Capacity Act 2005 were not fully understood by the management team.

Right Care
There were sufficient staff to meet people's needs. Most staff had the right skills and competency to meet people's care and support needs. Staff knew people well and the staff rota provided consistency for people who required this.

People received opportunities to lead active and fulfilling lives, social inclusion and independence was promoted as much as possible.

People had choice and access to sufficient food and drink.

Right Culture
The provider's governance arrangements did not provide assurance the service was well-led. Systems and processes to oversee the safety and quality of the service were effective and had not identified the shortfalls we found during our inspection. Although improvements had been made since the last inspection, these were ongoing and regulatory requirements continued not to be met.

Staff knew and understood people well. There was a clear commitment to minimising the use of restrictive interventions and supporting people to have choice and control over their lives.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was inadequate (published 11 February 2023).
We issued the provider with a warning notice asking them to make improvements in relation to person-centred care, consent, safe care and treatment, safeguarding, good governance and staffing. The provider completed an action plan after the last inspection to show what they would do and by when to improve in relation to requirements. At this inspection we found the provider remained in breach of regulations.

This service has been in Special Measures since 10 February 2023. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
This inspection was prompted by a review of the information we held about this service and to follow up from the previous inspection. We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively. We have found evidence that the provider needs to make improvements.

Please see the safe, effective and well led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment, safeguarding and good governance at this inspection.

We have imposed conditions on the provider's registration to drive improvement in the areas of concern highlighted above.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe	**Requires Improvement**
Is the service effective? The service was not always effective	**Requires Improvement**
Is the service well-led? The service was not always well-led	**Requires Improvement**

Boulevard House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 2 inspectors and an Expert by Experience made phone calls to relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Boulevard House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Boulevard House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We looked at the information we held about the service. This included, feedback, notifications and the actions taken by the provider since the last inspection. We requested feedback about the service from Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection. We used all this information to plan our inspection.

During the inspection
We spoke with 6 people who used the service and 5 relatives on the telephone. We spoke with 6 staff members. These included 3 care staff, 2 senior care staff and the registered manager. We looked at a range of information. This included 6 care records, 8 medicines administration records (MAR) and associated documents. We also checked 2 staff files, training records and information about the operation and management of the service.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

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

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13.

● Positive behaviour support (PBS) plans did not give appropriate guidance to staff on what restrictive interventions could be used if needed to keep people safe when they were at a higher level of distress. A generic statement was included in all people's PBS plans that said staff must use breakaway techniques if a person was to become physical. A staff member demonstrated a technique to an inspector which was more indicative of a restraint and not a technique used to break away from a person's hold. We could not be assured staff were sure what restrictive interventions had been agreed for each person to keep them safe.
● The manager had failed to implement a safeguarding log to show what incidents had been referred to the local safeguarding team. We reviewed an incident form which stated a person had caused harm to another person using the service. The registered manager told us there had been some previous incidents involving someone that no longer used the service. There was no evidence any of these incidents had been referred to the safeguarding team which meant potentially harmful behaviours were not appropriately reviewed.
● Safeguarding training was not prioritised for new staff. The provider's training matrix showed 2 new staff members had not completed safeguarding training even though they had been working in the service and supporting people directly. Safeguarding training is important to ensure staff have the skills and knowledge they need to identify and report abuse and neglect.
● Appropriate guidance or protocols were not in place when people's care plans stated they had made historic allegations against staff. We saw 2 examples in people's plans where it stated they had made allegations against staff in the past. However, there was no further guidance to ensure staff knew that all allegations should be taken seriously and reported to an appropriate person.

Systems and processes were not robust enough to ensure people were protected from the risk of potential abuse or harm. This was a continued breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Although protocols were not in place for when people raised concerns, all staff we spoke with knew how

to raise concerns and told us they would take any allegations seriously and report them.
● The provider had taken actions following our last inspection by creating PBS plans for each person. These contained person-centred information and some guidance for staff on how to support people when they started to become distressed to prevent restrictive intervention.
● Incidents had significantly reduced since the last inspection. There was a clear commitment to minimising the use of restrictive interventions and other restrictive practice.

Assessing risk, safety monitoring and management

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

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Control measures in place were not suitable for people who were not allowed to freely leave the premises because they would be at risk. The home had an open-door policy even though they supported people who were at risk if they left the home without support. We saw in incident forms that 2 people would leave the home when they were distressed which put them at increased risk of harm. The registered manager told us an alarm was fitted to the doors, but it distressed other people so it was switched off. The registered manager had not taken any further action to keep people safe.
● Personal emergency evacuation plans (PEEP) were not person-centred or realistic on how staff would support people in the event of a fire. All people's PEEPs stated they would evacuate to the car park, which was an open area next to the road. However, there were safer options that had not been considered and would have been more appropriate for some of the people supported.
● People's plans didn't always include important information for example, when they had epilepsy to ensure these additional risks were recognised and considered. People were at risk of harm because of potentially ineffective evacuation plans.

Using medicines safely
● Medicines were not always administered safely. We observed a staff member administering morning medicines to people without consulting the medication administration record (MAR). A MAR includes key information about people's medicines including, the medicine name, dose, special instructions and date and time. People were at risk of medicines not being administered safely.
● We could not be assured medicines were effectively reviewed to ensure people were not overmedicated. Although regular medicine reviews were carried out, the registered manager was unsure why people were on medicine long term when it was usually for short term or seasonal use. The registered manager told us they relied on medical professionals to review medicines and had not questioned the use of certain medicines to make sure they were appropriately prescribed. This meant people were at risk of being on medicines when not required which could lead to medicine related problems in the future.

Whilst we found no evidence that people had been harmed, the provider had failed to ensure risks were being effectively managed or medicines were being safely administered which put people at increased risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Care plans contained appropriate and up to date information about people's complex needs. Although

risk assessments had not been completed for some identified risks, care plans contained information to inform staff on how to support people safely.
● Medicines were stored safely and in line with current guidance. Controlled medicines were stored and managed safely. This meant people were protected from the risks of exposure to medicine not meant for them which could have serious implications to their health.

Learning lessons when things go wrong
● The provider was open and honest about the shortfalls found during the inspection and acknowledged there was work to do to improve the shortfalls identified.
● Debriefs had been introduced for people and staff which encouraged discussions after incidents to ensure lessons were learnt. Learning after events can identify areas of improvement to reduce the likelihood of incidents happening again.

Staffing and recruitment
● People were supported by adequate staffing levels to keep them safe and enable them to pursue individual interests and social opportunities.
● Staff were safely recruited. Pre-employment checks such as Disclosure and Barring Service (DBS) had been completed before staff started work. Checks provide information including details about convictions and cautions held on the Police National Computer.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● At the time of inspection there were no restrictions for visitors. The provider had an open visiting policy with no restrictions.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

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

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 11.

● The provider was working within the principles of the MCA. Where people lacked the capacity to make decisions about their care and were deprived of their liberty, capacity had been assessed and appropriate authorisations were sought from the local authority. However, the Deprivation of Liberty Safeguards and the key requirements of the MCA were not fully understood by the registered manager. When people had been deprived of their liberty, they had not always considered what those authorisations meant and what steps they needed to take to ensure people were kept safe. We reported on this in the safe section of this report.

Staff support: induction, training, skills and experience

At our last inspection the provider failed to ensure staff were provided with training appropriate to their role which put people and staff at risk. This was a breach of regulation 18 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18.

● Staff had their competency assessed for administering medicines. However, these had not always been effective as we observed a staff member administering medicine not in line with best practice which potentially put people at risk.
● Most staff had the skills and experience to meet people's needs safely. The registered manager monitored staff training on a training matrix. The training matrix showed staff had received training relevant to their role, although safeguarding training was not prioritised before new staff were working directly with people.
● Staff were required to complete the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care. It is made up of the 15 minimum standards that should form part of a robust induction programme.
● Staff received regular supervisions from the registered manager or the senior support workers. Staff told us they felt supported by the management team.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

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

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 9.

● People's needs were assessed and person-centred care plans were in place to instruct staff on how to support them in ways that upheld personal preferences.
● We observed staff supporting people in line with their agreed plans. For example, 1 person who became anxious was supported in line with their PBS plan and successfully redirected so the situation did not escalate. The person told us they were feeling better and were able to carry on with their day because of the support they had received.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff monitored people's health, care and support needs, but did not consistently act on issues identified. For example, a person's fluid intake was being monitored but it was not clear why and what actions had been taken to ensure they were receiving appropriate healthcare support. There was no evidence the person had been consulted and the registered manager told us it was potentially a behaviour why they drank so much which was just an assumption. This meant people were potentially at risk of not having their healthcare needs assessed and reviewed properly.
● Staff weighed some people weekly although it was not documented why. The registered manager told us 1 reason was because some people were overweight. There was no evidence weight had been discussed with people or that people had been given the opportunity to choose whether they wanted to access healthcare services to explore a healthier lifestyle. One relative told us, "I get the impression they're strict on not eating too much, and to look after their diets, but they always have a cup of tea as they want."
● Staff supported people to access the GP and other healthcare services. Relatives told us their family members accessed dentists and the GP when needed to maintain and monitor their health.

Adapting service, design, decoration to meet people's needs

● People had access to outside space with garden furniture so they could sit outside if they wanted to. The garden was not completely enclosed which did not support the needs of some people who could not leave the home without staff because of risk. Following our inspection, the registered manager told us they had reviewed the layout alongside the provider with a view to making this more suitable to people's needs.

● People's bedrooms were personalised and showed their personalities and individual tastes. One person told us some improvements they had made to their bedroom recently which made them happy.

● A bedroom on the ground floor had been created in line with a person's needs to keep them safe. A relative told us, "Their room's downstairs, which is safe, and they can't do more, and I'd say it's wonderful."

Supporting people to eat and drink enough to maintain a balanced diet

● People told us they enjoyed the food and liked to choose what they were going to have. We saw food of different cultures had been explored which gave people opportunities to try something new.

● People's personal preferences were considered and enabled by staff. A relative told us, "When [person] has been here and said they like the lemon tea, the staff say we'll get it then. They do listen to what they say."

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection the provider failed to assess, evaluate and improve their practice to monitor and improve the quality of the service and keep people safe. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● Governance systems and processes were not effective in ensuring actions taken by staff were safe and proportionate when people were distressed. A staff member recorded in an incident form they had used their training to release a person's hold on their arms but had not stated what intervention they had used. We could not be assured the registered manager was reviewing incidents effectively to ensure actions taken by staff were safe and proportionate.

● Risks had not always been identified or assessed. For example, when people were at risk due to medical conditions like deep vein thrombosis or epilepsy, assessments had not been carried out to ensure staff knew what actions to take to keep these people safe. This put people at increased risk of harm.

● There was insufficient oversight of people's monitoring records. The registered manager was unable to show they had effective oversight when staff were completing monitoring records for people when they thought they were at increased risk. For example, a fluid monitoring record was found but the registered manager was unable to evidence that any effective analysis had been made of the findings. They told us it was probably just a behaviour, although we found it stated in a staff meeting the management team were concerned about this person's fluid intake and it needed monitoring.

● It was not clear the management team fully understood the regulatory requirements of their role in upholding people's rights. For example, we found a lack of understanding in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards code of practice.

● Systems were not undertaken robustly enough to identify and monitor the quality of the service and

effectively drive improvements. For example, the maintenance log had issues that had been carried over to the next month with other reported problems disappearing off the list with no record of whether they had been completed. The registered manager told us they knew the hot water temperatures were going too high sometimes, although there was no action plan in place to rectify this problem. This meant it was not clear that concerns or issues had been managed and repaired to ensure the home was safe.

Continuous learning and improving care

● Body maps were not always reviewed after incidents. The registered manager was unable to locate a body map to show a visual record of injuries a person had sustained after being harmed. This meant we could not be assured records were available or accessible so they could be appropriately reviewed.

● Body maps that had been created, were not consistently reviewed to track progress and ensure appropriate treatment was being administered. This put people at risk of poor wound management and potentially more serious medical issues.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider had not always been open and honest. We saw in relative feedback forms that some relatives had been concerned about the findings at the last inspection. The responses from the provider to relatives were not completely honest or reflective about the outcome of the last inspection. The registered manager told us they had not wanted to unduly upset relatives or cause concern. This did not support the professional responsibility to be open and honest.

● The Care Quality Commission had not always received notifications when required. We found after a safeguarding incident where a person had been injured, a notification had not been received. Providers must ensure notifications have been sent to the Care Quality Commission for all incidents that affect the health, safety and welfare of people who use services as soon as possible after the event. We will continue to monitor and follow this up.

The provider's failure to effectively monitor the quality and safety of the service was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Following our last inspection, the provider had fully reviewed the use of restrictive interventions with an objective to reduce them. No physical interventions had recently been used by staff as planned early interventions had been successful which supported and promoted people's quality of life.
● Staff spoke positively about the leadership and management of the service and told us they felt appreciated and supported in their role. Staff understood the vision and values of the service and were committed to reducing the need of any restrictive interventions.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● The provider had not always worked closely with other agencies to ensure people were safe and incidents were appropriately investigated. This was reported in the safe section of this report.

● People had opportunities to offer their views about the quality of the service. These included face to face meetings or questionnaires. An easy-to-read feedback form had been created which included pictures to support people's understanding.

● Staff had opportunities to provide feedback to support learning and development. Staff meetings were held regularly, and questionnaires were sent out annually to encourage feedback.

● Most relatives knew who the registered manager was and told us they were kept informed and involved when appropriate in their family member's care and support. Questionnaires were sent out annually to request feedback and suggestions to improve the service.

● There was evidence feedback had been analysed and findings were reviewed by the management team. This meant the service was listening to people so they could improve people's experiences in the future.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not robust enough to ensure people were protected from the risk of potential abuse or harm.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure risks were being effectively managed or medicines were being safely administered which put people at increased risk of harm.

The enforcement action we took:

Impose a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to effectively monitor the quality and safety of the service

The enforcement action we took:

Impose a condition