Achieve Together Limited

Portland Street

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Portland Street is a residential care home providing accommodation and personal care for to up to 13 people. The service provides support to people with mental health support needs. At the time of our inspection there were nine people using the service.

People's experience of using this service and what we found
People were put at risk of harm due to the lack of safeguarding processes and effective systems in place to implement improvements where risks had been identified. Care plans and risk assessments did not always correlate and identify fundamental information to ensure people were supported in a safe way. People did not always receive their medicines in line with their care plans. There was a lack of staff trained in key areas for their role, which had an impact on delivery of care.

People did not get the support hours they were assessed as needing and this meant people were not always provided with safe support and were unable to experience new things or meet their aspirations.

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 and in their best interests; the policies and systems in the service did not support this practice.

The service was not able to demonstrate how they were supporting people in an open and positive culture. People did not receive support that was person-centred and gave them autonomy in their life. Relatives felt there needed to be a stronger focus on people's interests and ensuring their support was meaningful to them. Support did not focus on people's quality of life or follow best practice.

Staff told us and records confirmed there needed to be additional training to ensure there was enough appropriately skilled staff to meet people's needs.

The management team had not always offered the support and leadership required for the staff. The provider and manager had a governance system in place, which included various audits and monitoring, however, these were not effective and did not identify the issues we found.

There had been a recent change in management and immediate improvements had been made and this was recognised by the people living there and the staff.

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

Rating at last inspection
The last rating for this service was good (published March 2019).

Why we inspected
We received concerns in relation to the management of medicines and people's support needs. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of this full report.

Enforcement
We have identified breaches in relation to managing risks, adequately skilled staff, restrictive practice and the lack of quality assurance at this inspection.

Please see the action we have told the provider to take at the end of this report.

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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Portland Street

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.

Inspection team
This inspection was carried out by one inspector and a pharmacy inspector.

Service and service type
Portland Street is a 'care home'. People in care homes receive accommodation and personal care as a single package under one contractual agreement dependent on their registration with us. Portland Street 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 service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with seven people who used the service and two relatives about their experience of the care provide. We spoke with five members of staff including the manager and support workers.

We reviewed a range of records. This included two people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who regularly visit the service.

Inadequate

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 good. At this inspection the rating has changed to inadequate. This meant aspects of the service were not safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

● Staff recruitment processes were not conducted safely, this included reference checks and gaps in application forms. This meant people were at risk because they were supported by staff who may not have the right skills and qualifications required and who were not suitable to work with people using the service.

● The service did not have enough staff to support people safely. People and relatives said there was not enough staff to meet their support needs and manage situations where people were put at risk of harm. For example, where people started to feel their mental health deteriorating, they felt there was not enough staff to check in on them. This increased people's anxiety which resulted in people stating they were going to self-harm. One person said, "If you are ill it would be good to be checked on by staff." Another person said, they do not always feel listened to or helped when needed. They told us that "there is not enough help or staff do not understand". One relative said, "There is never enough staff, and three changes of management and all of a sudden it went wrong. I think [relative] needs more support, they do their best, they can't give the best to everyone."

● The rota indicated that people did not receive their one to one hours that they had been assessed as needed. The manager confirmed that upon starting at the service it was evident there was not enough staff to meet people needs. This meant people were at risk of not receiving the support they had been assessed as needing and that they were not able to take part in doing things they enjoyed which impacted their safety and wellbeing.

There were not enough staff to meet their needs. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At the time of the inspection the management team took action to ensure staffing increased to meet people's needs.

Assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

● People's risk assessments failed to give clear concise information and did not match with the information stated in the care plans. There were examples where we saw risks had been identified but risk management strategies were not in place or did not indicate how to support the person to mitigate the risks. One example being a person had a choking incident over two years ago, this was not identified in their care plan or risk assessment. At the time of the inspection the manager had put in a speech and language referral.

● People were not kept safe from avoidable harm. For example, we found safeguarding concerns had been identified and at the time of the inspection the provider had not taken appropriate action to ensure people

were kept safe. We raised a safeguarding alert following these findings.
● The provider and management had failed to have clear oversight of accidents and incidents, which meant incidents continued to be repeated. In addition, staff did not understand how to deal with incidents when they occurred. One person told us that they had told staff they were going to do something that caused harm to themselves and the staff did not help. Another person said, "Staff do not know how to deal with self-harm and issues relating to it." This put people at risk of significant harm.

● There was a lack of shared lessons learnt with the whole team and the provider. Where safeguarding concerns and risks emerged, the manager gathered the information relating to accident and incidents, however, did not effectively look at the overall trends and themes. This meant the manager and staff team were not able to learn and take steps to mitigate risks to people.
● Despite this staff were able to say how they would recognise any safeguarding concerns and report them. One staff member said, "First sign is physical sign, they have trouble explaining, if their mood is changed, it could be something that is playing on their mind, run out of money, find out what is going on and need to report it to keep people safe."

Using medicines safely
● The providers processes failed to support people to receive their medicines in a way that met their individual needs and aspirations for managing their own care. Assessments of knowledge and skill conducted with people living at the service indicated people wanted to work towards self-medicating where possible, but no steps had been taken to enable this in the years since reviews were completed. There was a document which provided medicines administration guidance to staff but was not adapted for each person.

● Detailed guidance specific to each person on how to administer medicines to be taken as and when required (PRN) was in place for some but not all PRN medicines prescribed. The level of detail in these documents to support staff to administer medicines safely varied. There were examples where the documents did not match the prescriber's instructions. The service had identified some of these concerns' months ago, but no action had yet been taken. We could not be assured that staff had the right information to support them to give these medicines safely when people needed them.
● Where staff were handwriting MAR chart entries based on changes or alterations to a prescription these did not always include enough information to ensure a medicine was being given as prescribed. There was often no authorising signature or witness signature for these entries to ensure it was matching the prescriber intentions.

People were at risk of harm. Systems were not robust enough to demonstrate safety was effectively managed. This is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● The providers approach to visiting aligned to the government guidance. People were able to see their relatives or friends if they wanted to and there were no restrictions on this.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● 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 accessing testing for people using the service and staff.
● 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.

Inadequate

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 good. At this inspection the rating has changed to inadequate. This meant the effectiveness of people's care, treatment and support did not achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- People were not supported by staff who had the relevant training relevant to people's needs. We found staff not having up to date training in, mental health awareness, safeguarding, acquired brain injury and The Mental Capacity Act. The manager had identified these as essential training for staff and a risk assessment had been completed which indicated these staff would not lone work until this training had been completed. However we found a number of examples where this was not the case and staff worked alone without the necessary training.
- People were supported by staff who did not have a sufficient induction. We spoke with a number of staff who said they had started work and felt they were 'thrown in the deep end'. One staff member said, "My induction, I hit the floor running, they were really short staffed, the new manager had not started, I got introduced to everyone. I got shown where everything was, what keys do what."
- People and their relatives did not feel staff had adequate skills and experience to support them and felt this resulted in people's break down of support. One relative said, "I don't think they have the right training and they need staff to be more skilled to support people. They need to be skilled to recognise things and I don't think they have." The manager acknowledged this and confirmed the staff needed to develop their skills and they had found scenarios where staff had not dealt with situations correctly and that resulted in people not receiving the support they needed which resulted in people's mental health deteriorating.

People were supported by staff who did not have the right skills or training to meet their needs. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

● People spoke about restrictions within the home. People described they were unable to enter parts of the home. For example, at night cupboards and fridges would be locked. People were unable to have access to snacks and drinks. One person said, "Food and kettle was locked away and this was stopped. Saucepans are locked, trays locked in the cupboard. Another cupboard that is locked." At the time of the inspection we observed that locks had been removed and when speaking with people they confirmed this had recently changed when the new manager started.
● People's mental capacity fluctuated at times due to their mental health. There were not considerations about what was in people's best interest during these periods of time. For example, one person was known to become intoxicated which resulted in them putting themselves at risk, during this period of time the person could not make a judgement about their care. There were not any discussions with the person about how they wanted to be supported during this time, or any documentation to consider what would be in the person's best interest. Another example, where staff told us they were locking away a person's tobacco at night, so they did not smoke, there was not documentation to indicate this was a best interest decision.
● Staff did not demonstrate a clear understanding on what the Mental Capacity Act meant within their role. Staff did not recognise the decisions they made where not the least restrictive or in people's best interest. One staff member said, "I find the whole idea of capacity confusing. I would say they have not got capacity as they are making bad decisions, but I need to have more understanding of it."
● The manager acknowledged they needed to develop staffs understanding on how the Mental Capacity Act impacted how staff supported people. Where people's mental capacity fluctuated the service did not ensure they had the right documentation or discussion with the right people the ensure this was in the persons best interest.

The service failed to demonstrate they had considered the "least restrictive" option when making best interest decisions, in line with the Mental Capacity Act 2005. This placed people at risk of harm. This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's care did not reflect the current evidence-based guidance when supporting people with mental health. For example, care and support plans did not always reflect people's needs and aspirations. Support plans did not focus on people's quality of life outcomes and meet best practice. One person said, "I don't know what's in it. We do this key worker sessions we write goals, but then nothing is really done. That's about it. I don't know if what is written in there is accurate. It is important that staff have the right information about you. It would be interested to read it."
●People said they wanted to be more involved in the development of the care plans and what was written about them daily.
● The provider and management had failed to ensure records were completed to clearly monitor people's general mood. This resulted in staff not being able to understand people's moods and actions and find ways to learn and provide the support that enabled people to stay healthy.
● We found examples where care plans did not correlate with health professional's guidance. For example, where people were prescribed medicines such as lithium or clozapine, they had not always got a risk assessment or care plan in place which identified signs and symptoms of lithium toxicity or neutropenia in

clozapine. Clozapine also did not have mention of the risk of constipation with that treatment.
● People did not feel their choices and wishes were respected. People described that staff did not respect their privacy and this was something that was very important to them. People told us that staff entered into bedrooms and people's personal space without consulting the individual.

The service failed to ensure people received support that was person centred. This was a breach of regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
● The provider and manager had plans in place to decorate and make adaptations to the property to ensure the environment was safe and well decorated. There had been delays in the works. However, the manager had confirmed the provider had started to schedule this in and purchase items needed to improve the environment.
● People personalised their rooms and were included in decisions relating to the interior decoration and design of their home, however they had requested furniture to be replaced due to some of these being damaged and were still waiting for this at the time of the inspection.

Supporting people to eat and drink enough to maintain a balanced diet
● People received support to eat and drink enough to maintain a balanced diet. People were involved in choosing their food, shopping, and planning their meals. We observed people having access to food, however people did say that they felt there needed to be better food and that food went very quickly.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The manager recognised that the staff and service were not always proactive in providing therapeutic support which would reduce the need for health interventions. This was something the manager planned to improve on. People were getting regular support from health care services and the service supported them with this.
● People and relatives spoke about their deteriorating health and gave examples of where staff may have not recognised where they needed support, and fed back to the staff and provider what support they needed, however there was no evidence this had been actioned by the provider. For example, people said they did not always feel listened to or helped when needed and would like more chats with staff, not enough activities.

Inadequate

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 good. At this inspection the rating has changed to inadequate. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not 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

- The provider failed to encourage a positive open culture within the service. The staff team did not always show the right values when supporting people, which resulted in safeguarding concerns. The manager acknowledged there were a number of restrictions when they started, and they still had a way to go to ensure the staff understood how to empower and give people choice and control, whilst developing a positive staff culture.
- We observed staff interactions to be caring on the day of the inspection, however we found further improvements needing to be made to instil a culture of care in which staff truly promoted people's individuality, protected their rights and enabled them to develop and flourish.
- During the inspection it was evident that the dynamics of the service user group and people's support needs, age demographic were different. When speaking with people all said they got on well with each other, however, did identify some points that questioned the compatibility of the people living there. One person said although they got on with most people, they would like to live with people their own age who had similar interest.
- The provider failed to ensure they delivered support in a way that met people's individual needs. People were clear about the improvement they wanted the provider to make and it was evident this had not been listened to, however since the new manager had at the service improvements had started to be made.

The culture of the service failed to support the provision of high-quality care and support. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There had been a recent change in management. People and staff reflected on the changes which they felt had caused some staff to feel unsettled, however felt that recently this had changed and there was more stability and they felt happier with the support they received. One staff member said, "[Manager] is fantastic, if you need something, they will pay attention, they will sit and listen. Things are getting done, and I can be part of the process."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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; Continuous learning and improving care

● The management team and provider had failed to ensure the quality assurance systems were reliable and effective. For example, we found they did not implement improvements to the culture of the service, Issues with safeguarding and restrictive practice were not always picked up, poor recruitment processes, inadequate staffing levels and gaps in staff training needs were not identified.
● The management team did not consistently capture actions to introduce improvements. These were not identified and lacked detail as to if these had been completed. The manager acknowledged this and as part of the start of their employment they had created an improvement plan and spoke about steps they were taking to improve the quality audits and action plans.
● The manager spoke about the need to develop their understanding on certain guidance relating to their role. The manager spoke about the need to develop the staff team as they felt there was an issue with staff professional boundaries within the service. Our findings confirmed this to be the case.
● The provider had failed to identify the failing in relation to the safety of people, staffing development and knowledge and the need to improve the overall culture of the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider had sought feedback from people, those important to them and staff, however actions that had been identified were actioned.
● The manager had put on team meetings where they started to gain views of staff and to have discussions about the service.

Quality monitoring systems were not robust enough to demonstrate the service was effectively managed. This placed people at risk of harm. This is a continuing breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others
● The manager gave examples of how they had regular input from other professions to achieve good outcomes for people.

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 10 HSCA RA Regulations 2014 Dignity and respect The service failed to ensure people received support that was person centred. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Warning notice issued

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service failed to demonstrate they had considered the "least restrictive" option when making best interest decisions, in line with the Mental Capacity Act 2005. This placed people at risk of harm. This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Warning notice issued

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were at risk of harm. Systems were not robust enough to demonstrate safety was effectively managed. This is a continuing breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Warning notice issued

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The culture of the service failed to support the provision of high-quality care and support. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Warning notice issued

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People were supported by staff who did not have the right skills or training to meet their needs. This placed people at risk of harm. There were not enough staff to meet their needs. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Warning notice issued