Chartwell Care Services Limited

Barclay Street

Inspection report

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30 January 2019

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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?	Requires Improvement
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

Barclay Street is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulated both the premises and the care provided, and both were looked at during this inspection.

Barclay Street accommodates up to seven people in one adapted building. At the time of the inspection there were five people in residence. Barclay Streets supports people with a learning disability and whose behaviour can be challenging. Some people also have Autism

This inspection took place on 28 January 2019 and was unannounced. We returned, announced on 30 January 2019.

Barclay Street had a registered manager in post. 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.

Barclay Street was previously inspected by the Care Quality Commission on 27 March 2017 and was rated good. This inspection found the key questions of is the service safe; effective; caring and well-led had not retained the rating of good. Therefore, the overall rating following this inspection has been reviewed and found to be requires improvement.

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

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

The provider had recently appointed a head of operations for adult services who had taken over the role of registered person. The registered person had undertaken a range of audits in key areas for the purposes of monitoring the quality of the service. The audits undertaken had identified key areas of improvement were required.

The provider had failed to maintain the environment and keep it clean. We found shortfalls in both communal areas and people's bedrooms. The lack of maintenance impacted on people's privacy and dignity. Work was being undertaken to bring about improvement within a given timescale set by the registered person. However, the resources had not been identified to achieve the improvements required. The provider had failed to plan the improvements to minimise the impact on people using the service.

Opportunities to learn from accidents and incidents to improve the support people received were not fully utilised.

Many staff had not completed or renewed their training in key areas to promote people's safety and welfare.

People were not fully supported to have maximum choice and control of their lives. Staff did not always support people in the least restrictive way possible. The policies and systems in the services had not fully recognised the need to assess people's capacity to make informed decision. Referrals had been made to relevant organisations to deprive people of their liberty which complied with the Mental Capacity Act (MCA).

Staff had very recently began to speak with people about their goals and aspirations, which has the potential to provide support to develop living skills, gain confidence and explore new ideas. People's support plans provided clear information about the support they required in all aspects of their daily lives, which included accessing activities and events within the community. Information as to the number of staff required to support each person was included within their support plan, with a majority of people receiving one to one or two to one support.

Potential risks to people were assessed. Plans to reduce risk including risks to people and staff where people displayed behaviour that challenges were in place. These were understood and implemented by staff. Staff had received training in supporting people when their behaviour became challenging. This had had a positive impact on people and had reduced the frequency for staff having to physically intervene to keep people safe. People received their medicine as prescribed.

Staff had a good understanding of people's needs and had developed positive relationships with people. This meant staff were able to respond when people became upset or anxious. People were supported by staff to access the community for health care appointments, recreational events and activities. Staff supported people to maintain contact with family members. Staff supported people to engage in activities within the service.

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 consistently safe.

The service had not been well maintained to ensure people's safety.

There was no consistent approach in place to review and learn from accidents and incidents.

Assessments to reduce risk were in place and implemented. Staff had received training in supporting people and maintaining their safety.

People were safeguarded from abuse. Systems and processes were in place which were understood by staff and referrals made. A system of staff recruitment was in place to ensure people were supported by suitable staff.

People's medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff training in key areas to promote people's safety and welfare was not up to date for all staff. Staff had received training in positive behaviour support, focusing on diversion techniques supporting people with a learning disability or autism.

People's capacity to make informed decisions had not been assessed as part of people's assessment of needs. Referrals had been made to relevant organisations to deprive people of their liberty as per the Mental Capacity Act.

The layout of communal areas and suitable outside space of the service did not sufficiently provide an opportunity for people to sit quietly and relax.

People's health and welfare were met. Staff supported people to attend health care appointments and encouraged people to eat a healthy diet.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Aspects of the environment compromised people's privacy and dignity.

People's involvement and views in the development and reviewing of their support plans was not clear.

People's support plans reflected the role of staff in promoting people's independence and choice, both within the service and when accessing the community.

People had developed positive relationships with staff, staff supported people to maintain contact with family members.

Is the service responsive?

Good

The service was responsive.

People's support plans provided clear information as to people's needs both within the community and at the service. Support plans were understood and implemented by staff.

People had access to information to help them understand their rights, which included how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider had failed to ensure a clear oversight as to the quality of the service being provided. Environmental improvements had not been implemented in a measured and planned way. The resources required for improvements had not been identified.

The provider had appointed a head of operations for adult's services and was the registered person. Audits undertaken by the registered person had identified areas for improvement.

People's views and that of other stakeholders had not been sought as part of the provider's quality monitoring.

Improvements to documentation to record and support people's needs had been introduced.

The format for meetings for people using the service and staff

had been reviewed, providing greater opportunity for their views to be sought.

Barclay Street

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We inspected Barclay Street on the 28 January 2019 unannounced. We returned announced on 30 January 2019.

The inspection was carried out by an inspector.

We looked at the information held about the provider and the service including statutory notifications and enquiries relating to the service. Statutory notifications include information about important events which the provider is required to send us. We used this information to help us plan this inspection.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We contacted Leicester City Council, who commission services from the provider.

We spent time with four people who used the service whilst they were being supported by staff.

We spoke with the registered manager, deputy manager, head of adult operations (registered person), a team leader and two support workers.

We reviewed the care records of two people who used the service. We looked at three staff records, to evidence their recruitment. We looked at staff training records. We examined documents which recorded how the provider monitored the quality of the service being provided.

Requires Improvement

Is the service safe?

Our findings

We found the service was not well maintained or clean. We undertook a tour of the service with the deputy manager and the registered person. A number of bedrooms were in the process of being decorated, which included the painting and the replacement of floor coverings. In addition, some en-suite facilities were being improved, which included the replacement of shower trays and toilets. We noted a very strong odour of urine in one en-suite and noted damp to the ceiling. A number of bedrooms did not have window dressings, we were told people who used the service, pulled these down and therefore frosted screening were used to maintain people's privacy, however this had peeled off some windows. Doors, skirting boards and walls were not clean, with dried marks from spilt drinks. Some carpets in bedrooms were stained.

We found wardrobes were not secured to the wall, which presented a potential hazard should they be pulled over. We brought this to the attention of the registered person, who organised for these to be fixed to the walls during the inspection.

The lounge had been stripped of wall paper and was to be redecorated. The conservatory, leading off from the lounge had stained carpet tiles and no dressings to the windows. The conservatory was cold, we were told it had under floor heating. One of the ovens in the kitchen did not work.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Premises and equipment.

The head of adult operations (registered person) told us action was being taken to bring about improvements. They shared with us an action plan detailing the improvements to be made.

We found opportunities to learn from incidents were missed, with no clear oversight and evaluation of incidents to further develop the service to improve the support provided to people.

We found accident and incident forms had been completed, which included the recording of incidents where people displayed behaviour that was challenging. However, in most instances the records had not been completed in full or comprehensively. For example, the details of lessons learnt recorded staff had followed the person's behaviour support plan, but they did not state what techniques were used to distract the person, what had or had not worked well. The form allows for information as to lessons learnt and a debrief from staff to be completed. This is to provide an opportunity to review the intervention to improve the support staff provide to people, this had not been completed nor had the section in relation to managerial oversight.

Records of the care and support provided by staff were electronically recorded. We found one entry of concern, which stated that staff had threatened to force open the door and restrain a person if they did not stop their behaviour. We shared this with the registered person, who took immediate action consistent with their policies and procedures in relation to the staff who had completed the record. The registered person ensured a safeguarding referral to the local authority was made and a statutory notification submitted to

the Care Quality Commission (CQC).

Staff told us that because of recent training in positive behaviour support (PBS), the frequency of the use of physical interventions had reduced. Staff told us a consistent approach and the use of distraction techniques had enabled them to better support people when their behaviour became challenging.

Risks to people's personal safety had been assessed and plans were in place to minimise these risks. There was a range of risks assessments in people's care records, which included when people accessed the community. This included the approach of staff to minimise risk when the person's behaviour became challenging. In some instances, where people's behaviour that challenges could not be managed by diversion techniques guidance was provided as to how staff were to physically intervene in a safe and controlled measure to keep the person and others safe. Staff had received training on how to restrain people safely.

Records of the care and support provided by staff was detailed within the electronic records, which included an account of the person's behaviour and the response of staff. Records showed staff spent time with people, talking with them providing reassurance. Techniques to distract people were used, which included the use of equipment such as a 'sensory weighting blanket', which is placed on a person to relieve their anxiety and stress.

People had an individual risk assessment for the evacuation of the service in an emergency, known as PEEP's (personal emergency evacuation plan), which highlighted the support each person would require. For example, the role of staff in supporting people whose behaviour maybe challenging because of the noise created by the activation of the fire alarm.

People's safety was supported by the provider's recruitment practices. We looked at recruitment records for staff. Staff recruited by the provider underwent a robust recruitment and interview process to minimise risks to people's safety and welfare. Prior to being employed, they had an enhanced Disclosure and Barring Service (DBS) check, two references and health screening. (A DBS is carried out on an individual to find out if they have a criminal record which may impact on the safety of those using the service).

People were supported to take their medicines safely by staff who had undertaken training in the medicine management. People however had not been assessed as to their knowledge, ability and willingness to manage their own medicines. We were told no one managed any aspect of their medicine independently and no once received their medicine covertly. People's care plans provided information as to the medicine people were prescribed. There was clear guidance on medicines to be given as and when required (PRN).

We looked at medicine administration records (MAR) and saw that they were completed. Where an administration procedure was not followed correctly, the deputy manager had taken the appropriated action.

The registered person and registered manager were not aware of STopping the Over-Medication of People with a learning disability, Autism or both (STOMP). STOMP is an initiative that has been set up by NHS England. We recommend that the provider finds out more about the good practice guidance in relation to STOMP and it's the potential of its implementation on people who use the service.

Staff were clear about their role and responsibilities to protect people from abuse and avoidable harm. Staff told us they had no concerns regarding people's welfare. Staff were aware of external organisations they could contact directly, which included the local authority and the CQC.

Policies and procedures relating to the promotion of people's safety, which included safeguarding, complaints and equality and diversity were available in 'easy read' format. Safeguarding and how to raise concerns was discussed at resident's meetings to raise the awareness of those using the service.

We found there were sufficient staff to meet people's needs and keep them safe. People were supported on an individual basis by one or two members of staff for differing periods of time throughout the day and night, dependent upon their needs.

Requires Improvement

Is the service effective?

Our findings

The staff training matrix identified some staff had not completed or renewed training in key areas. This included safeguarding, fire awareness, health and safety and food hygiene. The registered person had undertaken an audit of staff training and had identified shortfalls. The importance of staff completing their training had been discussed in staff meetings.

The staff training matrix showed that many staff had completed The Care Certificate, whilst some staff has completed a vocational qualification in health and social care.

Staff spoke positively of the recent training they had had in positive behaviour support (PBS), they told us the implementation of this approach had reduced the incidence of people demonstrating behaviour that challenges. Staff spoke of the need for a consistent approach to the support provided to ensure better outcomes for people. Training in PBS was ongoing, with ongoing support and training being provided. Staff told us they were confident in the use of ECCR (Ethical Care Control and Restraint). Staff used this approach when people's behaviour was challenging and required physical intervention to reduce the risk to the person and others.

Staff spoke positively about recent training in autism awareness. They said the training had been provided in part, by someone with autism, which provided a valuable insight as to how people living with autism interpreted sensory information. We asked staff how they applied this training to those they supported who had autism. Staff said when supporting people to access the community they considered the environment they would go to, to reduce sensory stimulation, especially when people appeared anxious or distressed. For example, by avoiding noisy or busy environments.

Staff told us managerial support through supervision and monitoring had improved in recent months. Records showed staff were supervised and the format of supervisions had changed to reflect staff development. Support was provided through staff meetings and the format of these had been reviewed to include a focus on the promotion of people's dignity, health and safety and staff training.

Barclay Street supports people with a learning disability and who have behaviour which challenges, with some having a diagnosis of autism. The environment design and layout is therefore a key factor in providing appropriate care. The service had a lounge; this room being a thoroughfare, giving the only access to both the kitchen and conservatory. This means that the lounge can be a busy environment having an impact on people's ability to relax. The lounge has patio doors which lead into the conservatory, which is used as the dining room, however this room provided no privacy as there were no blinds to the windows and we found it to be cold.

The conservatory provided access to the courtyard. The courtyard did not provide any facilities for people to sit and relax, there were no objects of interest for people to look at nor did it provide opportunities for people to undertake activities such as gardening to help people to manage their anxiety or to take part in hobbies or interests.

During our inspection, the sensory room and office were 'swapped' over. The sensory room became the office, and the office which has no windows was to be used as the sensory room to provide a controlled sensory environment. The operations manager informed us new equipment would be bought for the sensory room. The relocation of the office would enable a meeting place for visitors, which would reduce the impact of people using the service who had previously had to meet in the conservatory due to the small size of the original office space.

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 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 with appropriate legal authority. 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 and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. We found DoLS had been granted by the appropriate legal authority and where conditions had been made these were being met.

We found some people had restrictions imposed on them without a mental capacity assessment being completed, or an assessment carried out detailing why the restriction had been put in place. For example, we were informed that bedroom doors could be locked, however keys to the bedrooms were kept in the office. When we asked why people did not keep their own key, we were told "It's always been done that way." An example of another restriction was that a person who smoked was required to give their cigarette lighter to staff. The person's record stated why the person's lighter was not to be kept by them, however there was no evidence to support the person's capacity had been assessed or the decision for the person not to keep their lighter discussed with them and the least restrictive option adopted.

The registered person stated that staff had recently been made aware of the need to complete the relevant documentation and that they themselves had provided guidance for staff. Staff were seen to offer people choices throughout the inspection and supported people in the decisions they made, offering guidance and reassurance.

People's needs were initially assessed by the funding authority, who shared their assessment with the registered manager. The registered manager upon receipt of the assessment reviewed the information to decide whether they could potentially meet the person's needs.

People's records showed they were supported to access a range of health and social care professionals. Staff liaised with the relevant agencies on behalf of people where required, which included attending multi-disciplinary team meetings to review and plan people's care and support in consultation with them. People's health care needs were recorded within a personalised health action plan.

People did not require specialist diets but were encouraged to adopt a healthy diet. People contributed to menu planning with some taking part in grocery shopping. People were encouraged to contributed to preparing and cooking of meals, on the second day of the inspection Spaghetti Bolognese was on the menu and a person using the service was going to assist staff.

Requires Improvement

Is the service caring?

Our findings

The providers failure to ensure the service was clean and well maintained meant people's dignity was compromised. For example, one person had a duvet cover hung at the window instead of curtains. When we asked why, a member of staff told us they had been informed that the person needed to save money to buy curtains. The registered person, instructed a curtain pole and curtains be purchased as a matter of urgency. In other people's bedrooms, adhesive screening to people's bedroom windows was torn or missing.

People's support plans and the reviewing of these did not say whether the person themselves had been involved. A member of staff told us they had begun to sit with people to help them identify their goals and aspirations, so staff could start to support people to achieve these.

People were supported by staff to maintain contact with family members, in some instances this meant staff accompanying people when they visited their relatives. Some people could maintain independent contact with people and others involved in their lives via their mobile phone.

A member of staff told us one of the provider's values was to promote choice and independence and the importance of seeing everyone as an individual. Information in people's care plans provided key information to promote people's independence by recognising how staff were to communicate effectively. A person's support plan emphasised how a person was more likely to engage in an activity when it was approached using encouraging and inclusive language. For example, by saying 'Shall we'. instead of 'Can you'. Support plans provided guidance for staff as to how they were to encourage people's independence, for example one person's support plan stated how staff were to place money in the person's hand so that they could pay the driver when they used public transport.

People received support by staff to manage their day to day lives and to keep them safe. Staff we spoke with had a good understanding of the needs of people and were aware of how their approach towards people was a significant part of providing them with the support they required. Staff's awareness of people's needs meant they tailored the support they provided to be reflective of their needs, which could change quickly. This meant staff were vigilant for any signs of change in a person's mood so that they could divert people when they became anxious or upset. People's support plans provided key information to help staff to identify when people were becoming anxious or upset. For example, one person's support plan referred to a change in pitch of their voice, whilst for someone else it was their use of key words or phrases.

Good

Is the service responsive?

Our findings

The minutes of meetings showed, some people had requested to go on holiday and a number of locations had been identified by people. The deputy manager informed us people had not previously had the opportunity to go on holiday and this was an area for further development. People had the opportunity to go out on day trips, on the week of our inspection a number of people had visited the Sea Life Centre in Birmingham, some travelling by car and others by train.

People's aspirations and goals were in the process of being discussed with them. If implemented well, people's achievements of their goals and aspirations had the potential to improve people's quality of life and confidence. The documentation to support and record people's goals and aspirations was being slowly introduced. A member of staff told us they had started to work with people on a one to one basis, encouraging them to identify things they wished to achieve.

People's support plans provided clear information as to people's needs, which included the support they required when they displayed behaviour that challenges. The implementation of the approach of positive behaviour support meant people were encouraged to focus on positive things, which included what they enjoyed doing. This meant people were supported by staff to take part in a range of activities, which included swimming, bowling, shopping, going to the cinema and eating out. People were also seen to be supported in activities within the service, such as being encouraged to take part in daily household chores along with areas of personal interest such as playing games on mobile devices, colouring and art work.

Staff ensured people were kept safe and their right to make decisions about their day to day lives were respected and their independence and choices promoted. For example, people made decisions as to what time they got up, what they ate and drank and whether they accessed the services within the local community. Staff worked together as a team which enabled them to respond to people in a timely manner, promote their choices and keep them safe. For example, during our inspection visit we were aware that staff supported people to access local shops and parks and engage them in activities of choice within the service.

People had been encouraged by staff to talk about their wishes regarding end of life care or what they wanted to happen upon their death. People in some instances had said they didn't wish to talk about it, whilst others said they wanted a family member to make any arrangements.

Organisations that provide publicly-funded adult social care are legally required to follow the Accessible Information Standard (AIS) which says services should identify record, flag, share and meet information and communication support needs of people with a disability, impairment or sensory loss. We found the service had considered ways to make sure people had access to the information they needed in a way they could understand it, to comply with AIS. For example, people's assessments had identified any communication needs, which included information as to their reading and writing skills.

We saw that key policies and procedures, such as how to raise a concern; and information about eating healthily was provided in easy read format, supported by pictures and symbols to assist people in

understanding the information. We were told this information was usually displayed, however it had been removed due the decoration of the service.

The deputy manager told us people using the service had not raised any concerns. Information about how to raise concerns and who people could speak with were discussed in resident meetings. We saw there were positive relationships between people using the service and that service users expressed their views and opinions to staff.

Requires Improvement

Is the service well-led?

Our findings

Barclay Street had a registered manager in post at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider had recently appointed a head of operations for adult services who had taken over the role of registered person. The registered person had undertaken a range of audits in key areas for the purposes of monitoring the quality of the service. The audits undertaken by the registered person had identified key areas of improvement were required. One key area identified for improvement was the environment.

We found the provider had failed to consider and plan how to bring about the necessary improvements required to minimise the impact on people using the service and by ensuring there were sufficient resources available to bring about improvements in a coordinated and timely manner. We found there was poor communication between the provider and the registered person which impacted on the effectiveness of the provider, registered person and registered manager to make improvements.

At the time of the inspection, two maintenance staff were employed to complete the improvements. The lack of a coordinated approach, meant bedrooms and communal areas were undergoing improvements at the same time, with minimal consideration given to the impact on people using the service. Staff supported people to go out during the day to help minimise the impact on people. Throughout the inspection additional works were identified, which were assigned to the maintenance staff to complete.

The registered person told us they attended the Board of Trustee Meetings as part of their role as the registered person and head of operations for adult services. The registered person told us these meetings provided an opportunity for them to share key information as the quality of the service and improvements required following their audits and visits to the service.

We found there was a lack of managerial oversight of accidents and incidents, specifically those incidents where people's behaviour had become challenging. Documents were not completed comprehensively, there was limited evidence to support debriefings had taken place to a view to improving staffs' response to these incidents. Many of the incidents had not been reviewed by a member of the management team at Barclay Street.

People's views and that of others involved in their care had not been formerly sought as part of the provider's quality monitoring of the service provided.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance.

The registered person following the audits they had undertaken had introduced new documentation to record people's support needs. We spoke with the registered person who shared with us their plans for further improvements. These included the introduction of documentation to support people in identifying and achieving their aspirations and goals.

Audits had identified some staff training was not up to date and this had been highlighted to staff in meetings. Staff supervisions were being held with greater frequency and staff told us they felt supported by the management team. A reward scheme 'employee of the month' had recently been introduced to provide a financial reward for staff who showed they went above and beyond their role in supporting people.

The format of staff and resident meetings had changed with a focus on seeking people's views and driving improvement across the service. Audits had been introduced for staff to complete to support the registered manager in monitoring the quality of the service. Resident meetings focused on encouraging people to share ideas about the service and what they would like to see happen within the service. People were now being encouraged to talk about their personal achievements and what they proud of.

We sought the views of commissioners of the service as part of the inspection process. Their quality monitoring of the service had identified shortfalls in the maintenance of the environment and insufficient recording of incidents and accidents involving people using the service.

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 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to ensure and make suitable resources available to improve the environment and to implement the required improvement with consideration to the impact on people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure effective governance systems were in place to keep under review and improve the quality of the service being provided.