Brighton and Hove City Council

Brighton & Hove City Council - 83 Beaconsfield Villas

Inspection report

83 Beaconsfield Villas
Brighton
East Sussex
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Ratings

Overall rating for this service	Inadequate

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

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
Brighton & Hove City Council - 83 Beaconsfield Villas is a residential care home providing personal care to 6 people with learning disabilities and autistic people at the time of the inspection. The service can support up to 6 people.

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

Right Support
People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the systems in the service did not support best practice. Everyone living at the home required specific support and care to keep them safe and happy, there were positive behaviour support approaches for people, recommended by the local psychological support service. Some people had specific restrictive interventions recommended to protect them from harm at times of risk, and in their best interests. However, the service did not always have enough staff who had up to date skills and knowledge to provide the right support at the right time. People's records did not always show how decisions had been made about their support and how risks were reviewed and analysed.

Right Care
Care was not always person-centred and did not always promote people's dignity, privacy and human rights. There were not always enough staff to fully meet people's needs and ensure they had fulfilling lives. People's known interests and activities were not always enabled, this limited their opportunities to go out, exercise and do the things they liked.

Right Culture
Governance approaches were not effective in ensuring good standards of care, a safe environment, or to identify and lead required improvements. Some environmental risks within the home were known by the provider but had not been effectively assessed and responded to in a timely way to ensure people were safe. Audits and checks did not regularly take place to ensure the quality of care and support experienced by people was known and maximised. Staff were not adequately supported in their roles, training was not prioritised and levels of stress were reported to be high.

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 9 May 2019).

Why we inspected
We received concerns in relation to the level of staffing, how risks were being managed and the governance in place. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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.

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.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to failures to reduce risks to people, ensure safe staffing levels and to manage quality and safety, at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore 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 well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Brighton & Hove City Council - 83 Beaconsfield Villas

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
This inspection was carried out by 2 inspectors who visited the service and an Expert by Experience who contacted people's relatives for feedback. 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
Brighton & Hove City Council - 83 Beaconsfield Villas 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. Brighton & Hove City Council - 83 Beaconsfield Villas 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. However, they had been absent from the service for over a year and a variety of interim management arrangements had been in place.

Notice of inspection
This inspection was unannounced on the first day, we announced the second day of visiting.

What we did before the 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 reviewed the information we received from and about the service since out last inspection. We used all this information to plan our inspection.

During the inspection
People who lived at the home were not able to share their views about living there, some people did not know us well enough to meet with us. We observed some interactions between people and the staff supporting them. We spoke with all 6 peoples relatives by telephone.

We spoke with ten members of staff including 2 senior managers, the interim manager and support staff.

We looked at two people's risk management plans and medicine records and continued to review these following our visits. We reviewed 3 staff recruitment records, and the staff training records. We requested a range of documents relating to audits and governance, DoLS, building maintenance and safety records, and service improvement plans. We received these by email and continued to review these following our visits.

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 people were not safe and were at risk of avoidable harm.

Staffing and recruitment

- Risks with low staffing levels had been identified over the past year but were not resolved. The service was sometimes not able to provide the staff ratio which people required to be safe. This meant the prescribed behaviour support approaches, could not be used and people experienced less effective, higher risk support. Staff and managers gave us examples of incidents where less effective direct support had to be provided to people because there were less staff. This also meant people needed to have a higher level of restriction, as a form or protection in their best interests.
- People did not always have enough staff to support them to go out or spend time doing the things that improved their quality of life. Everyone living at the home required at least 1 to 1 support from a staff member, with some people requiring a higher staff number at times. This was not always available. Managers, staff and relatives told us staff shortages led to limited opportunities for some people to go out for accompanied walks or be taken for drives. These activities were very important to people's health and wellbeing and impacted negatively on them.
- There was no robust approach to ensure staff had consistent and relevant specialist training to meet the needs of people with learning disabilities and autistic people living at the home. The service training matrix showed that training about mental capacity and deprivation of liberty was not current. There was no formal training recorded about diverse methods of communication, approaches to building relationships or promoting people's rights and choices.
- New and agency staff did not receive a structured induction to their role and to people's specific needs and risks. People's needs were very specific, they required staff to understand how best to communicate with them and provide care and support which was tailored and meaningful to them. There were informal approaches such as shadowing staff and reading people's care and support plans, but there were no records to show learning had taken place. The lack of records meant the provider could not be assured staff had the right training, skills and knowledge to support people's tailored support plans.
- Staff did not receive regular supervision or appraisals to ensure they were supported, and their performance was monitored. There was an inconsistent approach to providing debriefs or meetings with staff following incidents and accidents in order to evaluate and learn. Staff and managers we spoke with were committed to the principles of good care but did not have the resources to provide the level of proactive support people required.
- People's relatives did not feel the provider responded in a timely way to ensure there were enough staff to provide safe and meaningful care. Relatives we spoke with found the staff caring but raised concerns about staff being overstretched and requiring specialist training. Relatives found the management and staff appointments to be inconsistent and changeable.

The lack of sufficient and suitable staff, and the failure to provide appropriate support and training is a

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

Assessing risk, safety monitoring and management

● The approach to fire risk safety was not robust. There was no overall fire risk assessment in place to ensure all building fire risks and mitigations had been identified and robustly reviewed. There was no risk assessment for fire door safety or the practice of having locked doors through the building. A risk assessment had not been carried out for the use of a fire escape which was used as an established exit from the building or the safety of other evacuation routes from the building.

● The building required maintenance and repair tasks to be completed. Some people's flooring was split and rotten and need of replacement. Wooden window frames around the building required a plan of action to repair or replace exposed wood. Some people's bathrooms indicated water leaks and black mould which needed resolving. Parts of the building had been deteriorating for some time without adequate maintenance and repair.

● Staff did not have up to date training about fire safety or evacuation plans.

● The personal emergency evacuation plans (PEEP) for people lacked coordinated and clear details about support needs and risks in an emergency. One person's PEEP stated they would need to share a car to sit in with another resident once evacuated, this was not noted in the other person's PEEP. It was anticipated that both people were likely to respond with heightened anxiety and experience greater risk during evacuation, but no reference was made to how each person could be safely supported in the car together. PEEP records identified 2 people who may need to be evacuated to the garden, 1 of the people needed to be the only resident in that area but this was not cross referenced or risk assessed.

The provider had failed to ensure the fire and building standards were properly and regularly maintained. This is a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff did not have recent training updates to ensure their risk-based knowledge and skills were consistent, safe and up to date. Most training, including first aid, health and safety and food safety had not been completed since initial induction. For many staff this dated back 3 years or more. Staff told us they didn't always remember their training because it was so long ago.

● People who lived at the home did not use verbal language to express themselves, some people liked to have verbal cues and gestures and other people liked to receive conversation or a mix of visual aids and cues. We saw some evidence of people's preferred visual communication methods around the home, however, we did not see staff using people's preferred methods consistently. This increased the risk of miscommunication, frustration and escalated upset for people.

● Where people had specific positive behaviour support plans and required risk-responsive interventions, analysis of all incidents and interventions was not consistently used to understand and make improvements to people's safety and wellbeing. Incidents deemed to be high level resulted in input from the behaviour support service, however we found there was sometimes little attention or recording about people's behaviour changed. This meant patterns, themes and interactions were not being analysed effectively.

● There had not been a robust approach to ensuring staff understood individual recommended approaches to managing risk with people. We found examples of incidents where staff had made incorrect approaches to a person who was at risk of swallowing objects. Guidance was not always followed, resulting in a more stressful experience for the person.

● People's relatives told us they were informed about updated risk plans but not all relatives had been invited to contribute to reviews. One relative noted a lack of support to go out for walks had led to weight gain and health concerns. This risk had not been promptly identified and acted on to prevent weight gain

occurring.

The provider had not ensured all practicable steps had been taken to mitigate safety risks to people. This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● The service was not always working within the principles of the MCA. Risk management plans for some people were not actioned effectively, so other people were restricted to protect them from unmanaged risks. Staff had not always followed people's agreed support plans when applying restrictions and interventions, such as overuse of locking doors and unnecessary physical intervention when responding to potential swallowing hazards.

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.

● Appropriate legal authorisations were sought or were in place to deprive people of their liberty within the DoLS framework. Conditions related to DoLS authorisations were being met and reported back to the local authority DoLS Team.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● Potential safeguarding incidents had not been robustly monitored and were not always consistently recorded or responded to. During our inspection visits we identified several historical incidents which had been recorded in support records, but had not been raised to the local safeguarding team for review. These had also not been notified, as required, to us at the Care Quality Commission. This limited the team's opportunity to learn from incidents in a timely way. Managers reviewed their records following our visits and ensured notifications were made to the local authority and CQC retrospectively.
● There was not always a robust approach to preventing incidents which could be anticipated. We received consistent feedback from staff and managers that staff shortages compromised people's support plans which were meant to ensure their safety and wellbeing. Some relatives shared concerns that positive support approaches were not well managed and led to some people's anxiety being raised. Staff did not always follow guidance to reduce risk, such as wearing a hat to reduce risk of hair-pulling.
● Staff we spoke with understood that incidents, accidents and concerns should be raised to managers. However, staff also told us they didn't always have time to directly manage risks and keep accurate records when there were not enough staff working. This resulted in not all incidents being analysed and discussed with staff or reviewed thoroughly to reduce further similar incidents.
● Some staff were not fully aware of the provider's policy or process for whistleblowing or raising concerns. Staff did not all know which agreed restrictions and prescribed restraints were in place for each person and they were not all confident to identify which restrictive practices should be used. Some staff were aware of

previous safeguarding incidents which had been escalated to managers but would not feel confident to question poor practices if they saw them.

Systems and processes were not effective in ensuring people were protected from the risk of abuse or unlawful restriction. 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.

Preventing and controlling infection

- Potential infection prevention and control (IPC) risks had been identified generically, but there had been no risk assessment or regular monitoring of actual risks and practices at the service. There was no IPC action or improvement plan in place to address risks.
- Infection prevention and control standards were not regularly monitored and maintained. The last infection control audit was dated July 2020.
- IPC written guidance to staff was out of date and had not been reviewed recently, or in relation to COVID-19. The IPC outbreak plan and standard used by the home were dated 2014 and 2016.
- We were not assured that robust cleaning and infection control practices were in place. We found kitchen and bathroom areas requiring thorough cleaning. People's personal hygiene items were stacked in a stairwell and on an open bathroom shelf instead of securely in a cupboard. We found a blue colour coded mop head, usually used in low hygiene risk areas, drying on a bucket in a high hygiene risk area next to a toilet.
- One person's allergy to dust mites was known, however this had not led to actions to ensure the communal areas were cleaned and less impactful for the person's health.

The provider had not taken adequate steps to ensure risks of infection were prevented and controlled. This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting in care homes

People's relatives were encouraged to visit, and people were enabled to maintain active and meaningful relationships with people who were important in their lives.

Using medicines safely

- Medicine audits did not take place regularly to ensure medicine was properly stored and managed. Out of date stock and excess stock remained in medicine storage cupboards which were dirty and also contained non-medicine items. We spoke with managers about the need to clean, organise and check medicine within the medicine cupboards, this began to be addressed during our visit.
- Medicine which was given to people as they required it (PRN) was not clearly monitored. Where people had PRN pain relief, constipation medicine and medicine to reduce anxiety, records did not clearly show how people's symptoms were monitored before and after administration.
- The provider's medication policy had not been reviewed since 2019. The policy was intended for review in 2021 but had not been checked to ensure it followed current guidance for best practices in medicines management.

The provider had not ensured the safe and proper management of medicines. This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- The provider did not ensure people and staff were safe. Staffing levels were inadequate for responding to people's known risks and assessed needs, this placed people at risk of harm.
- Overall governance systems were not effective. A deterioration in safety and increase in risks had been identified by the provider over the past year, but action had not been taken to address these. The service risk assessment had been reviewed but it was unclear who was responsible for leading change, taking actions and what the target timescales were.
- Management audits had not taken place at the service to ensure people's safety and to identify specific issues for improvement. For example, the issues we found with medicine management, environmental concerns, care records, staff supervision and training, cleaning and fire safety were not subject to regular audits or a drive for improvement.
- Managers had not identified all of the statutory notifications they needed to send us about safeguarding concerns and incidents. These are notifications the provider must send us to meet the regulations. Notifications were sent to us following our inspection.
- Although known risks of staff stress, physical harm and reduced quality of care were longstanding there had not been an effective response to mitigate these risks.
- Staff did not receive regular feedback or opportunities to develop their skills and knowledge. There was little individual or team approach to reflect on the performance of the service or the experience of people living at the home.
- Team meetings did not take place. There were limited or no opportunities for the whole team to meet to support each other, discuss the service or work towards service improvements.
- There was a high turnover of staff, and interim management arrangements which provided inconsistent leadership. People's relatives told us the high staff turnover was unsettling for people who needed familiar staff working with them.
- Staff morale was low, staff experienced high levels of stress. Inadequate staffing levels had led to staff and managers being stretched to provide the support people needed. Staff had low confidence that the team worked consistently and shared the same knowledge and skills.

The provider had failed to ensure governance systems were effective in monitoring service quality, responding to poor quality and driving improvement. This is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Staff, managers and people's relatives did not feel the service had been led well or consistently. During the registered manager's absence there had not been consistent management oversight of the home. A high proportion of agency staff worked at the service and there was a high absence and attrition rate. Staffing shortages meant interim managers and senior managers often worked staff shifts instead of undertaking management tasks, such as audits, supervision and reviews.

● There was little understanding among staff and managers about national guidance to provide right support, right care, right culture within the service. Managers did not have time to provide individual supervision to staff or to manage staff training needs so there was little evidence of a drive for person centred practice or a culture which ensured good outcomes for people.

● Staff did not always use and record language which was person centred and respectful. Terms such as complying, resisting and yielding were used in people's records to describe whether they chose to do things. Behaviour support forms prompted staff to describe people in terms of severe non-compliance, aggressive or stereotypical. We spoke with a manager about the use of language, which was de-personalising and de-humanising, they agreed terminology needed to be reviewed and changed.

The provider had failed to ensure people received a personalised service which met their assessed needs and risks. This was a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People's relatives felt able to approach staff and managers about any concerns they had, but did not always have confidence that actions would be taken to make improvements. Some relatives told us they had been raising the same concerns about staffing and quality of care for many months, but little had improved.

● Where people had regular contact and support from relatives, or had clubs and groups they liked to attend, this was encouraged and enabled by staff. However, some people's relatives felt they needed to provide extra support due to lack of staff availability to take people out or provide them with meaningful interactions.

● Staff told us they did not have a forum to raise concerns and ideas. Staff felt their training and development had not been prioritised by managers.

● Relatives told us they were updated about incidents and concerns, but they were not confident about how well issues were managed. Relatives told us individual staff conduct was addressed but overall management of risk was not.

The provider had failed to ensure concerns were responded to and improvements made without delay. This is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Managers and staff had regular contact with the local Behaviour Support Service which provided specialist review of incidents people experienced regarding distress, anxiety or when high risk and harm was experienced.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure people received a personalised service which met their assessed needs and risks.

The enforcement action we took:

We issued a warning notice and will return to ensure improvements have been made.

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 not ensured all practicable steps had been taken to mitigate safety risks to people. The provider had not taken adequate steps to ensure risks of infection were prevented and controlled. The provider had not ensured the safe and proper management of medicines.

The enforcement action we took:

We issued a warning notice and will return to ensure improvements have been made.

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 effective in ensuring people were protected from the risk of abuse or unlawful restriction.

The enforcement action we took:

We issued a warning notice and will return to ensure improvements have been made.

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 the fire and building standards were properly and regularly

maintained.

The enforcement action we took:

We issued a warning notice and will return to ensure improvements have been made.

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 governance systems were effective in monitoring service quality, responding to poor quality and driving improvement. The provider had failed to ensure concerns were responded to and improvements made without delay.

The enforcement action we took:

We issued a warning notice and will return to ensure improvements have been made.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were sufficient and suitable staff, and failed to provide appropriate staff support and training.

The enforcement action we took:

We issued a warning notice and will return to ensure improvements have been made.