Bayrose Limited

31 Whitwell Road

Inspection report

Southsea
Portsmouth
Hampshire
PO4 0QP

Tel: 02392793941
Website: www.pathways-support.co.uk

Date of inspection visit:
03 November 2016

Date of publication:
24 February 2017

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Good**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

On the 3 November 2016 we inspected 31Whitwell Road. At the time of our inspection, there were eight people living there. This was an unannounced inspection.

31 Whitwell Road is registered with the Care Quality Commission to provide the regulated activity: Accommodation for persons who require nursing or personal care. The service is a care home without nursing and supports people with a learning disability. The service can provide accommodation for a maximum of nine people.

The service was last inspected in July 2014 and was not fully compliant with the outcome areas that were inspected against. Medicines were not managed in a safe or proper way.

The service had a registered manager but they were not present at the time of our 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 and associated Regulations about how the service is run.

Staff knew how to recognise and respond to abuse. They understood their responsibilities and who to report concerns to. However we found safeguarding issues had not always been reported to the local authority safeguarding team or notified to the Care Quality Commission.

Staff were supported to carry out their roles. There was a plan in place to ensure all staff had a one to one meeting with the registered manager. However staff had not always completed the training they needed to carry out their roles.

Medicines were not stored appropriately. We observed people received their medicines when they needed it and were encouraged to be as independent as possible when taking their medicines. Records for medicines were not always present.

People were involved in developing and shaping the service. People were involved in daily life within the home such as in the cooking and cleaning.

The provider had quality audit tools in place. However these had not identified the risks to people's health and wellbeing.

People and their relatives spoke positively about the support they received. They said staff were kind and caring. Staff treated people with respect and dignity. However the environment did not always support people's privacy and dignity. We have made a recommendation about this.

Regular fire drills were undertaken and people and staff knew what to do in the event of an emergency.

There was enough staff to meet people's needs. People were able to do the activities they wanted and attend all of their appointments. Before staff started working at the service all the necessary checks were carried out to ensure staff were suitable to work with people.

All staff had an understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff had looked for the least restrictive options when depriving someone of their liberty.

People were supported to prepare and eat balanced and nutritious food. People attended a variety of healthcare appointments and staff supported people to be as independent as possible.

People decorated their rooms in the way they wanted and their loved ones could visit whenever they wanted.

People were involved in writing their care plans and risk assessments. They received the care they needed, in line with their wishes. People were actively involved in the local community and various local clubs.

There had been two complaints in 2016 which had been dealt with appropriately. People and their relatives told us they were in regular contact with staff and felt they could raise any issues if they arose.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. CQC is currently considering the right regulatory response to the problems and issues we found at the inspection on 3 November 2016.

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.

Safeguarding concerns had not always been shared with the local authority safeguarding team.

We identified a number of significant concerns with the environment. Regular checks were carried out on the environment and equipment but these safety concerns had not been identified.

Medicines were not managed or stored safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not always completed training that the provider had identified as essential in their role.

Staff had an understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). People were supported to make important decisions about their lives.

People regularly saw healthcare professionals. There was guidance in place to ensure people were supported with their health needs.

People were supported to have a healthy balanced diet

Is the service caring?

Requires Improvement

The service was not always caring.

People were treated with dignity and respect and were encouraged to be as independent as possible. However the environment did not always support people's privacy and dignity. We have made a recommendation about this.

People decorated their rooms to their personal preferences.

People and their relatives said staff were kind and caring

Is the service responsive?

Good

The service was responsive.

People were actively involved in the local community. They regularly took part in activities visited local points of interest and social clubs.

The registered manager and provider had worked to ensure people had a say in the planning of their care.

There had been two recent complaints about the service which had been handled appropriately. People and their relatives said they would speak to staff if they had any concerns.

Is the service well-led?

Inadequate

The service was not well-led.

Actions from previous inspections, including electrical safety inspections, had not been addressed.

Management had not completed audits relating to the quality of care or paperwork. Audits for medicines and the environment had not always identified the serious concerns we found.

Staff told us they had trust in the manager and felt the service was well led.

People and staff were involved in the decisions on the future of the service.

31 Whitwell Road

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. We also checked whether improvements had been made following our previous inspection in July 2014.

The inspection took place on the 3 November 2016 and was unannounced.

The inspection team consisted of one inspector.

Before the inspection took place, we looked at the information the Care Quality Commission (CQC) held about the service. During the inspection, we spoke with three people that used the service and one relative.

We spent time observing care and speaking with the operations manager and two support workers. The registered manager was on leave during the time of our inspection. We looked at three people's care records, three staff files as well as documentation relating to the management of the service such as training records and policies and procedures. We also reviewed information we had received about the service such as statutory notifications. We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider had completed and returned this form to us.

.

Inadequate

Is the service safe?

Our findings

People told us they felt safe living at Whitwell Road. One person said, "I have lived here a few years and am very happy here." Another person confirmed they felt safe. A relative who visited the service told us they had, "No reservations and I know [person's name] is safe."

The registered manager carried out monthly visual safety checks of the environment and equipment to make sure it was safe to use. These included ensuring that electrical and gas appliances were safe. The operations manager provided us with an up to date gas safety certificate. The registered manager carried out monthly visual safety checks of the environment and equipment to make sure it was safe to use. These included ensuring that electrical and gas appliances were safe. We had concerns with the wiring on the day of the inspection. We asked for the current five year hardwiring certificate. We were sent a copy post inspection of a certificate dated June 2014 which related to the concerns following the inspection in April 2014.

During our walk around of the service accompanied by the operations manager we identified several areas of concern. There was wiring stretched across the walls. The edging on an upstairs bath stuck out creating a sharp point. The bath panel on the side of a bath was loose. Exposed wooden features were in the bathroom areas that could harbour bacteria. The general state of furniture was very tatty and worn.

There was a broken shelf with sharp edges left in a person's bedroom. Another person's bedroom had cleaning products in an unlocked cupboard that could be harmful if consumed; this was addressed by the operations manager on the day of the inspection. In the kitchen, two cabinet doors had broken off and we opened a third cupboard door which dropped off its hinges.

Flooring in the bathroom areas was cracked and not always stuck down properly. One person's bedroom on the top floor of the property had windows without restrictors on. The operations manager told us this person sometimes leant outside the window to communicate with people. We ensured the operations manager addressed this concern on the day and notified the local authority safeguarding team of our concerns in relation to the environment.

This was a breach of Regulation 15 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in July 2014 we found medicines were not consistently managed in a safe or proper way. At this inspection we identified concerns remained. Medicines were not always stored securely. Some medicines were stored in people's rooms. Three people's medicines were contained within wooden cabinets not secured to a wall. One of these cabinets was broken leaving all the medicines easily accessible to everyone. We opened one wooden cabinet and found two loose tablets were on the base of the unit and were unaccounted for from records. A large number of medicines that were to be returned to the pharmacist had been left in the office unsecured.

There were arrangements in place for obtaining, recording, administering and disposing of prescribed medicines. However we found Buccal Midazolam stored in a broken wooden cabinet in someone's bedroom. This did not comply with safe storage of medicines. We ensured the operations manager addressed this concern on the day of the inspection. We found more bottles of Buccal Midazolam stored in the basement, and six bottles of medicine were all out of date. This posed a risk should a person require this medicine staff may automatically take the one nearest to them..

Medicines administration recording had been completed in line with guidance from the National Institute for health and Care Excellence. We found medicines had been signed for, although as there was no stock balance recorded for boxed medicines, it would be difficult to audit medicines effectively to ensure all medicines were accounted for. We found full Medication Administration Records (MAR) for six people containing confidential information in the open office. Medicines that were to be given on an as and when required basis did not have a protocol in place. This is a protocol that describes to staff when they should administer this medicine safely reducing inconsistency in administration. We informed the operations manager about all the medicines concerns we had and they apologised and agreed there was a lot of work to do. The operations manager told us they would be getting someone in to complete a full medicines audit and they would also be looking at their working practices.

Two of the six care staff had completed their medication administration training, the other four were in progress and had therefore not fully completed appropriate training.

This was a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a policy in place regarding safeguarding adults and how to recognise and respond to different types of abuse. Information about how to report any concerns and whistleblowing was available at the service for all staff to refer to. People said they were aware of what abuse meant and how staff should protect them. Staff told us they knew how to recognise and report different types of abuse. Staff told us they would report any concerns to a senior staff member. However we saw staff safeguarding training had not been completed by five of the six support staff. This meant that staff may not be up to date with the latest safeguarding practice.

The registered manager had recorded safeguarding incidents in order to monitor them. However we were unable to find on the day of inspection any referral forms to show us they had been reported the City of Portsmouth's safeguarding team. There had been a large number of incident or accidents including potential safeguarding concerns in the 12 months prior to inspection but this had not always been reported to the CQC. The operations manager told us they thought they had been referred but were unable to find evidence of this.

We found one incident where the registered manager had recorded as part of their review, that the information must be passed to the local safeguarding team as a safeguarding referral, however this information was not shared as stated. The incident records we viewed on the day were all related and were within three months of each other. We were concerned that without the local authority being aware an appropriate protection plan was not put in place.

This was a breach of Regulation 13 (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had identified the risks associated with people's care, such as mental health, medication and

community activity. Each care plan explained how to manage these risks and ensure people received the care they needed to minimise the risks from occurring. There were detailed risk assessments in place assessing the support people needed with their daily lives. People were supported to take positive risks such as using sharp knives and boiling a kettle with the risks around them cutting or scalding themselves minimised by staff.

Regular checks were carried out on the fire alarms and other fire equipment to make sure they were working properly. Staff and people were regularly involved in fire drills and people had a personal emergency evacuation plans (PEEP) in place. A PEEP sets out the specific physical and communication requirements that each person has to ensure that they can be safely evacuated from the service in the event of an emergency.

People said that there was enough staff and there was always someone available when they needed them. One person told us, "They help me when I need it." We observed people on the day of inspection being supported with their needs. The registered manager had assessed people's needs and ensured there were enough staff to meet them. The operations manager said they looked at people's dependencies regularly to make sure they were still accurate. Staff were available to support people to access the activities they wanted to and to attend all their appointments.

The registered manager and operations manager shared an on call system so were available out of hours to give advice and support. The staff team was quite small and they had all been working at the service for some time so they knew people well. If staff were unavailable the rest of the team covered the shortfall.

Recruitment procedures were thorough to make sure that staff were suitable to work with people. Written references were obtained and checks were carried out to make sure staff were of good character and were suitable to work with the people. Disclosure and Barring Service (DBS) criminal records checks had been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Requires Improvement

Is the service effective?

Our findings

Staff were not always trained and supported to gain the right skills, knowledge and qualifications necessary to give people the right support. Whilst we saw the staff were working on their care certificates we could not see that staff had completed the provider's mandatory training courses. (The Care Certificate is an identified set of standards that health and social care staff adhere to in their daily working life. The Care Certificate gives everyone the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.) We could not be assured that staff had completed training which would ensure that people at the service were safe.

The training matrix provided to us indicated four of the six care staff were in 'progress' with completing all the provider's mandatory training. This showed us most staff had not fully completed courses that were identified as being required for their role and risked that they did not support people effectively.

Staff had not had their competency checked when administering medicines. This lack of training and competency check supported the unsafe storage of medicines which increased the risk of a mistake being made. We saw staff who had recently administered medicines had not completed or were not up to date with their safe administration of medicines training. Staff spoke about people's needs with knowledge and understanding and related their training to these people.

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

People told us that they thought staff were well trained and knew them well. One person said, "The staff are great and they help me." A relative said, "They know what they are doing, they are all very good."

The registered manager had a plan in place to ensure all staff had regular one to one meetings by the registered manager. Staff told us they felt well supported by the management and they had sufficient opportunity to speak with them if they required. We looked at supervision notes for people and found they offered support with staff's personal development and addressed any work related concerns. Annual appraisals had taken place.

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

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the service had referred five people for a DoLS assessment, one had not been granted yet, whilst four people had had their DoLS authorised.

Staff had received training on MCA and DoLS and spoke confidently about people's capacity to make decisions. One staff member said, "We encourage everyone to make as many decisions for themselves as possible."

People said they liked the food and were supported to be as involved as possible when making food and drinks. People regularly went into the kitchen to make themselves hot drinks. Cereals and bread were out on the counter and people were able to help themselves to whatever they wanted for breakfast. One person said, "I am going to go downstairs and decide what I want for breakfast." People were supported to help prepare meals for everyone. People and staff told us they regularly discussed meal options. The monthly plan for meals was displayed in the kitchen and these were on the menu. One person who used the service had a gluten free diet. We noted a large selection of gluten free foods and staff were aware of this need.

Two people were at the service for lunch. They had been asked individually what they would like to eat. Staff told us if people did not want something that was on the menu then they were free to ask for anything else in the house.

Staff assisted people to attend a variety of healthcare appointments and check-ups. People were supported to be as independent as possible when making their appointments. One person told us staff helped them if they were feeling unwell and they had been to the doctors. The outcome of all appointments was recorded clearly and risk assessments and associated documents were updated regularly as a result.

There was information in place for people to take with them if they were admitted to hospital. This laid out important information which healthcare staff should know, such as how to communicate with the person and what medicines they were taking. People had health action plans in place detailing their health needs and the support they needed.

Requires Improvement

Is the service caring?

Our findings

People spoke positively about the care they received and the kind and caring nature of staff. We saw numerous natural, humorous interactions between staff and people. One person said, "I always have a laugh and a joke with the staff." Another person said, "We get on very well." A relative told us, "[person's name] is very happy, he has everything he needs. Staff are all very good."

Most people had been living at the service for many years and there was a stable staff team most of whom had worked there for a long time. Staff had built strong relationships with people and knew them well. There was a friendly and inclusive atmosphere and people helped with the upkeep of the service by cooking and cleaning. Everyone had good things to say about the staff and everyone said they liked the staff.

Staff knew how to communicate with people effectively. Throughout the day staff moved to gain eye contact from one person and knelt down to their level. They spoke slowly and clearly and the person was able to understand everything that was said to them. Another person required time to process what was said to them. Staff told us sometimes they had to repeat information to make sure the person understood better. Staff interacted with people in a positive and reassuring way.

People were encouraged to keep their home clean and tidy. There was a rota of jobs that people carried out so people helped out in a fair and equitable way. For example one person helped to wipe down the tables after meals. These jobs were discussed at residents meetings to make sure people were happy with what they were doing. Some people required more encouragement to look after their home than others. Plans were in place to indicate to staff the best way to support them with their responsibilities.

Staff supported people to be as independent as possible. We overheard a member of staff outside the bathroom supporting a person with their bath. The staff member was quietly describing what to do so they could do it for themselves. We observed at lunch time people were encouraged to make some of their own lunch. On the day of inspection many of the people who lived in the service went out to a place of their choice.

People were involved in recruiting new staff so they could have a say about who supported them. The operations manager told us potential staff would visit the service and people would be asked for their opinions. The operations manager said this was important as staff needed to fit with the people, as it was their home. This demonstrated the service recognised the importance of involving people in the running of the service.

People's relatives and friends were able to visit whenever they liked. One relative told us their loved one liked living at the service and that they tried to visit as much as possible. They said, "I just ring them up and let [person's name] know I am coming. If they are not in then I come another time."
One person's support plan said that they needed to be prompted to go to the bathroom. A member of staff asked the person discreetly in a quiet voice, if they required the toilet. Another person had a doctor's appointment in the morning. Staff explained why it would be good to go and any potential consequences of

not going. The person still refused to go and this decision was respected.

However we saw the home's environment was not always suitable to ensure people's dignity and privacy was respected. On the day of inspection we saw in the en-suite in a shared bedroom on the ground floor, the window was clear and gave a clear line of sight from the neighbour's house into the shower with no curtain or blind. After the inspections the provider told us they had added frosting to increase privacy and dignity. We will follow this up at the next inspection.

We recommend the provider reviews the arrangements for providing privacy and dignity when using the bathrooms in the property.

People personalised their rooms in line with their particular likes and preferences. The operations manager told us people had the choice of colours when their room was being decorated. We saw rooms were filled with people's personal effects.

People were encouraged to use advocacy services if they were needed. An advocate is someone who supports a person to make sure their views are heard and their rights upheld. The operations manager told us that no one currently used an advocate, but they had done so in the past. Information was displayed about advocacy and the support it offered to people.

People's care plans and associated risk assessments were stored securely and locked away. This made sure that this information was kept confidentially. However people's medication records which documented their personal details and why they received specific medicines had been left in the office with the door open.

Good

Is the service responsive?

Our findings

People were supported to access the activities they wanted and were involved in planning their care. One relative said, "We are invited to the reviews." One person said, "I tell staff what I like to do and I get to do it."

Before people came to live in the service staff completed an initial assessment. Initial assessments then fed information into the persons care records. People were involved in writing their care plans and associated risk assessments. Records were written from a position of the person's strengths, for example describing to staff what the person was good at, and how staff could further promote their independence. Staff clearly knew everyone well and were able to describe to us what help or support an individual needed. We saw people had signed their care plans to show they had helped to write them and agreed with the contents. One person explained the things they liked to do themselves and when staff offered them assistance. Their care plan reflected what they said.

Staff were supported to understand people's method of communicating because there was clear guidance in people's support plans. For example, one person did not always communicate verbally. Their plan explained what the person might mean by the way they were communicating and what staff needed to do to help them. Staff confirmed they understood people's individual communication skills, abilities and preferences and this enabled them to respond to their needs promptly. Staff understood what people wanted or needed and were able to make sure people had a voice. We observed staff responded to people's needs promptly and took time to make sure they understood what the person needed.

People were actively involved in the local community. People had been to local sites of interest, crazy golf, theme parks and social clubs. People also took part in a range of activities based at the service. Days important to people were celebrated as a group and staff told us they encouraged everyone to get involved. For example one person recently had a birthday party and a member of staff learned to play one of their favourite songs on guitar. This encouraged other people in the service to join in.

There was a guide on making complaints that was available at the service in an easy read format. The operations manager said there had been two complaints in 2016. We looked at these complaints and saw they had been followed through as per the direction in the provider's policy. Complaints had to be recorded, investigated and responded to and analysed for trends. One relative told us small concerns had been addressed quickly and they had no complaints.

Inadequate

Is the service well-led?

Our findings

Some audits relating to health and safety and the environment were carried out regularly. However other audits focussing on people's care and any associated documentation had not recently occurred. The operations manager told us a new monthly audit tool was being introduced but this had not started yet. A medication audit was carried out but was not robust as it had not identified the areas of concern we raised on the day of inspection. The operations manager told us there was no specific robust audit of the care records. Environmental audits took place but had not identified all of the concerns we raised on the day. This showed us the service did not have a robust quality assurance process in place. We identified key failings with the safety of the service during this inspection with serious concerns identified relating to the premises, management of medicines. This showed a failure of quality assurance systems.

The service had not acted on feedback from relevant persons including the Care Quality Commission. At the last inspection in July 2014 we found medicines were not managed in a safe or proper way. A robust plan of improvement should have been put in place to drive the necessary improvements that we highlighted in 2014.

This was a breach of Regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All of the people, relatives and staff we talked with during the inspection spoke positively about the registered manager and the way the home was managed. People and relatives told us that the registered manager was always available to them if they had queries or concerns and that other staff in the home were also very helpful. One person told us, "I have been here a few years and I like it. I just tell staff if I don't like something." They added that they knew that they would be listened to and that action would be taken when they raised any issues.

There was a registered manager in place but they were not present at the time of the inspection. Staff said that they felt well supported by management. Staff told us they had an understanding of culture and values of the organisation and knew which direction they were headed as an organisation. Staff also said they felt able to raise any concerns with the registered manager and were confident that they would be addressed.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. CQC check that appropriate action had been taken. On the day of inspection we noted a number of safeguarding incidents that had been recorded but had not been shared with the CQC. After the inspection we spoke with the local authority's safeguarding unit who confirmed they had also not been notified of the safeguarding concerns. This showed us notifications had not always been submitted to CQC in an appropriate and timely manner in line with CQC guidelines. Systems therefore were not operated effectively to identify that these incidents needed reporting to CQC and the local authority.

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