

Mr Donald Smith

Trafalgar Street

Inspection report

Priory Lodge
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South Yorkshire
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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

Trafalgar Street, also known as Priory Lodge, is a care home providing personal care to 3 people at the time of the inspection. The service can support up to 4 people.

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.

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

Right Support

Improvement needed to be made to the environment people lived in to ensure it was clean and well maintained. We have made a recommendation to the provider about this. Staff were aware of people's strengths and what they could do and supported people to make their own choices about their care and support needs. People were being supported by staff to be actively involved and engaged in cooking and completing their own household tasks. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. Staff learned from incidents and how they might be avoided or reduced. Staff followed safe practices when wearing personal protective equipment (PPE).

Right Care

People and their families told us staff were kind and supported them well. Staff understood how to protect people from poor care and abuse, they had received training on how to recognise and report abuse and were able to tell us when they would report any concerns. We observed staff interacting with people in a kind and compassionate way and in a way that promoted people's independence. People received support from staff who knew them well, understood their needs and considered their preferences.

Right culture

Quality assurance processes had not identified all the concerns in the service. The service had a registered manager who was also registered manager at another 2 care homes. People and staff were very positive about the registered manager. However, we identified shortfalls in systems used by the provider and registered manager to check the quality and safety of the service. These needed strengthening and embedding into practice. Managers understood further work was needed.

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

Rating at last inspection and update

The last rating for this service was requires improvement (published 02 March 2020). The service remains rated requires improvement. This service has been rated requires improvement for the last 2 consecutive inspections. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected

We carried out an unannounced comprehensive inspection of this service on 26 March 2020. A breach of legal requirements was found. The provider completed an action plan after the last inspection to show what they would do and by when to improve governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

When aggregating ratings with those from a previous inspection add the following wording. Note, ratings cannot be aggregated with 'inherited ratings' awarded to a predecessor location.

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 remained requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Trafalgar Street on our website at www.cqc.org.uk.

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.

Following the inspection, the provider responded by taking actions to improve. You can see what action we have asked the provider to take at the end of this full report.

Enforcement and Recommendations

We have identified breaches in relation to safety and management. Please see the action we have told the provider to take at the end of this report.

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Trafalgar Street

Detailed findings

Background to this inspection

The inspection

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

Inspection team

The inspection was carried out by 2 inspectors.

Service and service type

Trafalgar Street 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. Trafalgar Street is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager

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

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

Notice of inspection

This inspection was unannounced.

What we did before inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us

annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection

We spoke with 2 people who used the service and 3 relatives about their experience of the care provided. We spoke with 4 members of staff including the registered manager and support workers. We reviewed a range of records. This included 1 person's care and medication records. We looked at 2 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at quality assurance records and training information.

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 requires improvement. The rating for this key question has remained requires improvement. This meant some aspects of the service were not always safe and there was inconsistent assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Overall risks were assessed and monitored. However, we found the provider had not considered the risk of falls from height and there was no assessment of risk or preventative measures in place. For example, we found 4 window restrictors were not in place on upper floor windows. A window restrictor is a safety device which prevents a window from opening too wide to reduce the risks of people falling out.
- The provider's audit process did include a system to ensure window checks were completed but they had not recognised or assessed the need for window restrictors to be in place, therefore a safety issue had been left unaddressed.

Whilst we found no evidence of harm to people, the provider had failed to ensure the proper and safe management of risks to people. This placed people at risk of harm. This was a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Some other areas of safety were managed well. For example, risks to people such as choking or self-harm had been assessed and were regularly updated.

Staffing and recruitment

- Safe recruitment procedures were in place and references and DBS information were being gathered prior to people starting work. However, the recruitment checks taking place on staff suitability were not robust.
- Further improvements were required to ensure the accuracy of application forms, employment history and verification of references. We discussed this with the registered manager who took action to address the shortfalls and assured us going forward the process would be strengthened.

We recommend the provider reviews their recruitment process to ensure it is robust.

- There were enough staff deployed to meet people's needs and keep them safe.
- Staff supported people to access the community frequently to do activities such as going to the gym or going on local walks.
- Throughout our visit we observed staff supporting people in a calm, relaxed and friendly way. Staff did not rush people, and we heard laughter and joking amongst them all as they carried out tasks. When people asked for support this was given promptly.

Preventing and controlling infection

- We were partially assured the provider was promoting safety through the layout and hygiene practices of

the premises. We found the home was clean in some areas whilst some frequently touched areas of the home, like door fronts and paintwork, were visibly dirty. However, cleaning records showed cleaning had been completed.

We recommend the provider strengthens the processes used to check and monitor the cleanliness of the service.

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

Visiting in care homes

- There were no restrictions on peoples' relatives and friends being able to access the service and visit people.

Systems and processes to safeguard people from the risk of abuse

- Staff had training on how to recognise and report abuse and they knew how to apply it.
- People and those who matter to them had safeguarding information in a form they could use, and they knew how and when to raise a safeguarding concern.
- Relatives told us their family members were safe. One relative said, "[My relative] is safe. Staff sort things out straight away."

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)

- We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Using medicines safely

- The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff understood and implemented the principles of STOMP (stopping over-medication of people with a learning disability, autism or both) and ensured people's medicines were reviewed by prescribers in line with these principles.
- Staff reviewed each person's medicines regularly to monitor the effects on their health and wellbeing and provided advice to people and carers about their medicines.
- People were supported by staff who followed systems and processes to administer, record and store medicines safely.

Learning lessons when things go wrong

- Incidents and accidents were monitored and reviewed to identify any patterns or trends. They were analysed for any necessary action and learning was discussed with staff

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 requires improvement. The rating for this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

At our last inspection, a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was identified. This was because the governance of the service was not effective, or robust. At this inspection, not enough improvement had not been made and the provider was still in breach of this regulation.

- Since the last inspection the registered manager has been registered to manage another 2 locations. Although their time was being shared between all 3 locations equally, we identified the registered manager was juggling various issues and time management was not effective.
- The provider had a variety of quality assurance processes in place which included a range of audits. However, these had failed to identify all the shortfalls we found. For example, shortfalls in recruitment checks, safety, mandatory training and policies and procedures not being in place. This meant the quality assurance processes in place were not always effective in identifying concerns, or if they had, driving the necessary improvement.
- Some of the concerns identified at this inspection were the same as at previous inspections, such as audits not picking up issues. This demonstrates learning had not effectively taken place.

The failure to have effective systems in place to assess, monitor and improve the quality and safety of the service was a continued breach of regulation 17 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

- Formal feedback had not been gathered from people or stakeholders. The registered manager was aware of this as an area to address in the near future and plans were in place to send out formal feedback requests.
- Staff told us they felt involved in the service and the registered manager was very supportive.
- Relatives were very positive about the support their family members received and felt able to give feedback on how the service was doing when they spoke with staff or the registered manager.

- Staff were involved in meetings about the service and people were involved if they chose to be.

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

- The registered manager took time to interact with relatives and respond positively to their comments. One relative said, "Yes, the service is well managed, we know the manager and they ring us. We have a good rapport with the staff who keep in contact via email or text."
- The registered manager understood their responsibilities and were open and transparent when accidents/incidents occurred.

Working in partnership with others

- The registered manager was working alongside the provider to introduce policies and procedures to embed the improvements to the providers locations.
- The manager continued to work with the local authority team to improve the quality of care, in addition to external organisations.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider had failed to ensure the proper and safe management of risks to people. This placed people at risk of harm.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider failure to have effective systems in place to assess, monitor and improve the quality and safety of the service. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>