MyLife Supported Living Limited

Burbank Mews

Inspection report

1-4 Burbank Mews
Burbank Street
Hartlepool
Cleveland
TS24 7NY

Tel: 01429851352

Date of inspection visit:
19 February 2020
20 February 2020
21 February 2020
25 February 2020

Date of publication:
03 August 2020

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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Burbank Mews provides personal care for up to 12 people with a learning disability and/or autism in six bungalows. Nursing care is not provided. At the time of inspection eight people were using the service.

The service has been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance; however, the principles and values were not always being upheld. We expect that services that uphold these principles and values ensure that people living with learning disabilities and/or autism are supported to live meaningful lives that include control, choice and independence. We found this was not always happening in practice.

People's experience of using this service and what we found
The service was not well-led as we identified six breaches of regulation. The provider had failed to have enough oversight of the service. Systems to monitor the quality and safety of the service and support continuous improvement, both at registered manager and provider level, were not effective.

People did not receive consistently safe care and medicines were not always managed safely. Staff recruitment procedures were not thorough. Accidents and incidents had not been analysed thoroughly to look for trends so lessons could be learned.

Staff training and supervisions were not up to date. People's weight was not monitored effectively and care plans specific to people's health needs were not always in place.

People were not always 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 policies and systems in the service did not support this practice.

The service was not working within the principles of the Mental Capacity Act 2005. Mental capacity assessments and best interest decisions had not always been carried out when they should have been.

The service didn't always consistently apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.

The outcomes for people did not fully reflect the principles and values of Registering the Right Support as people's views had not been sought and we could see how they had been involved in care planning.

People told us they enjoyed living there and liked the staff who supported them. Most staff knew people's needs well and people seem relaxed and happy in the presence of staff. Most staff were caring, respectful and ensured people were treated well.

Some staff did not always engage with people in a meaningful way and spent time doing other things. Some staff did not regard the people they supported as equals, so did not fully respect their equality and diversity.

Care plans had not been reviewed regularly, were not always up to date and were not always consistent.

There was a lack of consistency across each of the bungalows in terms of staff approach and record keeping. There was evidence of the service making appropriate referrals to other health professionals, but staff did not always follow this advice consistently.

Quality monitoring systems were not robust or effective and did not drive improvement. The result of this was people did not always receive good quality care.

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 13 July 2018).

Why we inspected
The inspection was prompted in part due to concerns we received about the increase of safeguarding incidents, the quality of care records, excessive use of agency staff and staff training not being up to date. A decision was made for us to inspect and examine those risks.

Enforcement
We have identified breaches in relation to person-centred care, the need for consent, safe care and treatment, good governance, staffing and fit and proper persons employed. Please see the action we have told the provider to take at the end of this report.

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
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
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?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

Burbank Mews

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 Care Act 2014.

Inspection team
The inspection team consisted of two inspectors and a specialist advisor who was a learning disability nurse. Two inspectors and a specialist advisor visited on the first day of inspection, two inspectors visited on the second day of inspection; and one inspector visited on the third and fourth day of inspection.

Service and service type
Burbank Mews is a 'care home.' People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission, although they were absent when we visited. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals involved in the service. We used all of this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service

does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with three people who used the service and one relative about their experience of the care provided. Some people were unable to tell us about their experience. We observed the support people received and their interactions with staff in each of the six bungalows.

We spoke with 19 members of staff including the operations manager, the advanced care practitioner, a team leader, two senior support workers and 14 support workers.

We reviewed a range of records. This included six people's care records. We looked at four 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.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● Risks were not always well managed. Risk assessments relating to people's individual needs were not always in place to guide staff. Where risk assessments were in place, these had not been reviewed regularly to ensure they reflected people's current needs. One person's risk assessment did not reflect a change in their lifestyle. Four people did not have appropriate risk assessments in place to prevent pressure damage.

● Staff did not discuss and agree approaches and interventions to be used for the people they supported. Each person had a core team but staff were sometimes inconsistent in their approach. In some of the bungalows, staff had different views on what would be best for the person they supported. For example, what they ate and drank, but there was no reference to this in people's care plans.

● People had positive behaviour support (PBS) plans but staff did not always follow these effectively. These should help staff understand the reason for the behaviour, so they can better meet people's needs, enhance their quality of life and reduce the likelihood that the behaviour will happen. One person's care plan did not mention how staff should support them when they behaved in a way which could be challenging for them. PBS plans had not been reviewed regularly, so we could not be sure they were up to date and reflected people's current behavioural needs.

● A fire safety audit carried out in September 2019 identified that a fire door in one of the bungalows was damaged and needed to be repaired or replaced. This had not been done.

● The electrical condition testing of each of the bungalows was due in December 2019. Whilst there were no obvious electrical defects this should have been carried out. The operations manager assured us this would be carried out immediately. Other regular planned and preventative maintenance checks were up to date.

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

● Risk assessments relating to the environment and other hazards, such as fire and food safety were carried out and reviewed regularly.

Learning lessons when things go wrong

● Staff reported they had been told to only record 'serious incidents,' so we could not be sure all incidents had been appropriately recorded. Daily notes were often at odds with incident logs, in terms of people's presentation. For example, whilst daily notes gave the impression someone had had a good day, incident records documented they had had extended periods of distressed behaviour. This meant it was difficult for both staff within the service and external professionals to gain an accurate picture of people's needs and whether interventions were working.

● There was no effective system to analyse accidents and incidents to reduce the risk of them recurring.

Information collected was not detailed enough, which meant trends could not be identified. We could not be sure lessons were learned if things went wrong. A new way of analysing accidents and incidents was being developed.

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

Staffing and recruitment
● Recruitment procedures were not safe which placed people at risk of harm. Staff files did not contain full employment histories, records of interviews had not been completed fully and the appropriate number of references had not always been sought or checked. This meant adequate background checks had not been carried out to ensure staff were safe to work with vulnerable adults. Disclosure and Barring Service Checks had been carried out but these had not been recorded accurately.

This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were enough staff to meet people's needs. There had been a high turnover of staff but this had decreased recently. Whilst agency staff had been used this had reduced.

Using medicines safely
● Medicines were not always managed safely. Guidance for staff on 'when required' medicines was not always person-centred. For example, where medicine was prescribed for distressed behaviour, one person's care plan stated it was 'used to calm down when highly agitated' with no explanation what that looked like for that person. Staff who supported this person regularly could describe this, but there was no guidance for new or agency staff to refer to.
● Staff did not always record the reason they had given 'when required' medicines, or the outcome for the person, to show whether the medicines had been effective. Where guidance on this was available, this had not been reviewed regularly. One person's 'when required' guidelines had not been reviewed since early 2019.
● One person's 'when required' medicines guidance differed from what was on the medicine administration record. This placed the person at risk of harm.
● Staff did not always adhere to when required protocols. For example, one person was given their medicine after 45 minutes rather than the one hour required.
● Medicine stocks matched some records but daily audits were incorrect. Staff had not taken account of medicines left from the previous month. This could have led to staff being unaware if medicines were missing.
● Staff recounted incidents over the last month where a person had not accepted their medicine, or they had taken it later than prescribed, but records did not reflect this.

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

Systems and processes to safeguard people from the risk of abuse
● Staff had completed safeguarding training and knew how to raise concerns.
● Safeguarding incidents had been investigated and reported to the local authority appropriately.

Preventing and controlling infection

- People's bungalows were clean and tidy.
- Staff had access to protective personal equipment and had completed training in infection prevention and control.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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. 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.

- The service was not working within the principles of the MCA. Although all eight people who used the service had a DoLS in place, mental capacity assessments and accompanying best interest decisions had not always been carried out when required. For example, three people had received the flu vaccine but no mental capacity assessments or best interest decisions were in place.
- Staff told us one person who had specific needs around eating had capacity to decide what to eat, but there was no capacity assessment to reflect this. It was unclear if this person understood the risks involved.
- Staff supported people to manage their finances, but there was no information whether this was related to their lack of capacity to manage money.
- Staff told us one person had restrictions placed on them when they ate a meal, but there was no mental capacity assessment or best interest decision regarding this.
- One person needed to attend a routine health screening, but staff told us they would not be able to tolerate this. There was no mental capacity assessment or best interest decision regarding this. It was not clear whether the person understood the risks of not attending this health screening.
- It was clear from our conversations with staff that some staff did not have a good understanding of the MCA or DoLS.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support; staff working with other

agencies to provide consistent, effective, timely care

● People's weight was not monitored effectively or recorded consistently. Staff told us everybody had their weight checked monthly but records did not confirm this. For example, records indicated one person's weight had not been checked in February, July, August, September, November and December 2019 and January 2020.
● Key information which helps determine if people are a healthy weight or at risk of malnutrition was not recorded. Staff told us one person didn't always want to get weighed, but records didn't reflect this; neither was there any guidance for staff on how to support the person with this.
● Two people did not have oral health care plans in place.
● Staff did not consistently support people with diabetes to make healthy choices about what to eat.

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

● Staff supported people to attend regular healthcare appointments, but records regarding this were disorganised. For example, it was difficult to see when people had last had a dental check-up or a medicine review, as this information was not easy to find in people's files.

Staff support: induction, training, skills and experience
● Staff did not always have the skills to deal effectively with people's individual needs, as they had not completed relevant training. For example, out of 68 staff only 35 had done PROACT SCIP-r UK (Positive Range of Options to Avoid Crisis and use Therapy training). This is a proactive approach to support people when they are distressed or in crisis.
● No staff member had completed training in oral care. This was contrary to NICE guideline [NG48].
● Staff in one person's core team had not completed bespoke positive behaviour support training, despite this being offered by a professional involved with the service. Previously it had been arranged, but not put on the staff rota, so staff didn't turn up. During the inspection the operations manager rearranged this training. Staff told us they needed bespoke training so they could ensure they provided person-centred care for people with complex needs.
● The provider's supervision policy was for staff to have supervision every two months. This policy was not being adhered to as most staff had only received two or three supervisions in 2019.

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

Supporting people to eat and drink enough to maintain a balanced diet
● Staff supported people in eating and drinking what they chose. But where people had specific needs around their diet, it was not always clear if they understood the risks of not following professional advice; neither was it clear whether they had capacity to make such a decision.
● People had ready access to food and drink outside mealtimes, with staff support if necessary.
People were supported to buy their own food where possible, and staff were aware of people's preferences regarding food and drink.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Assessments of each person's needs were completed before a care placement was agreed or put in place.
● Following the initial assessment, risk assessments and individual support plans were developed.

Adapting service, design, decoration to meet people's needs

- The environment met the needs of the people who lived there. The home was located within a residential area and gave no indication of being a care home.
- People said they liked where they lived. People's bungalows and bedrooms were personalised.
- Gardens had level access to aid mobility and areas of fencing provided privacy.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- Most staff were caring in their approach, but some did not regard the people they supported as equals, so did not fully respect their equality and diversity.
- Staff did not always engage in a meaningful way with people. Some staff spent a large amount of time in the office when there was no apparent need.
- Most staff were caring, respectful and ensured people were treated well. We received positive feedback from people who lived there about their core staff teams. People told us they enjoyed living there and liked the staff who supported them. Most staff knew people's needs well and people seem relaxed and happy in the presence of staff.

Supporting people to express their views and be involved in making decisions about their care

- There was limited information about how people were supported to express their views and were involved in making decisions about their care.

Respecting and promoting people's privacy, dignity and independence

- People's independence was not always promoted. Where there were risks associated with people's behaviours, not enough consideration had always been given to positive risk taking which would promote people's independence.
- We saw when people chose to spend time in their rooms, staff respected this as their private space, and knocked before entering.
- Staff were sensitive when people displayed distressed behaviours and ensured their dignity was respected during such times.
- People's private and confidential information was kept secure.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; end of life care and support

- Care plans had not been reviewed regularly and were not always up to date. Individual support plans to support specific areas of need were not always in place. For example, one person required support to regulate their emotions, but there was no guidance on this for staff to follow. We found no evidence to suggest people had seen their care plans, or the content had been explained to them, and they had agreed to them.
- Care plans were not always consistent. For example, one person's care plan stated there were no issues around eating and drinking, but also stated this person was at risk of choking. Another person's care plan contained information about how best to support the person using a particular piece of equipment, but staff said this information was out of date as the equipment was no longer used. Another person's care plan stated they had an unconfirmed diagnosis of a specific condition, but elsewhere the care plan stated they had this condition. The original care plan had not been updated to reflect this.
- People did not have care plans in place around how they would like to be cared for at the end of their life. Whilst most people who lived at the home were younger adults and not expected to die whilst there, not all were.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- The provider was not meeting the requirements of the AIS as people's care plans were not available in an accessible format.
- Key information about the service, such as how to make a complaint, was available in alternative formats appropriate to people's needs.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Staff supported people to maintain relationships which were important to them and to do the things they liked. Staff supported people to make decisions about how they wanted to spend their time, such as going to the local shops, walking, playing football, watching films or spending time in the garden. People regularly

accessed the local community.

Improving care quality in response to complaints or concerns

● The provider had a complaints procedure in place and a relative told us they knew how to make a complaint if necessary. People who could express their views said they would speak with a member of staff if they felt something was wrong.

● Complaints were dealt with effectively and promptly.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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

- There was a registered manager in post but they were absent during our inspection. The provider's operations manager had been overseeing the service for the past four weeks before our visit.
- Quality monitoring systems were not robust or effective and did not drive improvement. The result of this was people did not always receive good quality care.
- The registered manager had failed to identify the risks we found during our inspection. This meant they had not mitigated the risks, and as a result, people were at risk of harm. For example, audits had not identified the concerns raised during this inspection such as medicines not always being managed safely, staff training and supervisions not being up to date, accidents and incidents not being analysed thoroughly and the principles of the MCA not being followed.
- Care records were not always complete and accurate. People's weight was not monitored effectively or recorded consistently. Systems were not in place to monitor and oversee people's weights and this was not being audited appropriately. Positive behaviour support plans had not been reviewed regularly, so we could not be sure they were up to date and reflected people's current behavioural needs. The provider's quality monitoring systems had not identified all of these issues in a timely manner.
- Staff had not been adequately supervised and staff turnover had been high.
- There was a lack of consistency across each of the bungalows in terms of staff approach and record keeping.

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

- The operations manager had identified the above issues needed immediate improvement about a week before our visit; an action plan was being worked on when we visited.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Feedback from people and relatives had not been sought for over a year.
- Staff said morale had been low but were hopeful this would improve with the operations manager now overseeing the service. The operations manager had previously been the registered manager at this service. Staff said they hadn't always felt listened to or supported previously.

● One staff member said, "Staff morale is better now [operations manager] is here. It's lifted people." Another staff member said, "Things are better now. There was an increase in professionals visiting due to more safeguarding incidents, which made the staff feel under pressure. [Operations manager] knows where we need to improve and they'll help us do it. We've got faith in them."
● Before the inspection we received feedback from professionals that the service was not well-managed.
● There were processes in place to help ensure that if people came to harm, relevant people would be informed, in line with the duty of candour requirements.

Working in partnership with others
● There was evidence of the service making appropriate referrals to other health professionals, but staff did not always follow this advice consistently.

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 9 HSCA RA Regulations 2014 Person-centred care People's care plans were not appropriate to their needs. It was not clear how people had been involved in decisions about their care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not acting in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed effectively. Risks relating to the health and safety of service users were not assessed and appropriate action was not taken to minimise those risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to conduct appropriate checks to ensure that staff were of good character and had the qualifications, competence, skills and experience necessary.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure staff received appropriate support, supervision and training.

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 17 HSCA RA Regulations 2014 Good governance The provider failed to assess, monitor and improve the quality and safety of the service. The provider failed to maintain an accurate, complete and contemporaneous record for each service user. The provider failed to seek and act on feedback from relevant persons.

The enforcement action we took:

Warning notice.