Parkcare Homes (No.2) Limited

Tithe Barn

Inspection report

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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

About the service
Tithe Barn is a residential care home for people with learning disabilities.

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. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. People using the service receive planned and co-ordinated person-centred support that is appropriate and inclusive for them.

The service was a large home, bigger than most domestic style properties. It was registered for the support of up to 13 people. Eleven people were using the service at the time of our inspection. This is larger than current best practice guidance. However. the size of the service having a negative impact on people was mitigated by the building design fitting into the residential area and the other large domestic homes of a similar size. There were deliberately no identifying signs, intercom, cameras, industrial bins or anything else outside to indicate it was a care home. Staff were also discouraged from wearing anything that suggested they were care staff when coming and going with people.

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

People were not supported to have maximum choice and control of their lives and staff did not 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 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 for the following reasons [lack of choice and control, limited independence, limited inclusion] e.g. People did not have choice in the food they ate or at what times meals were served. Menus were developed by staff with no input from people who lived at the service.

Since our last inspection the provider had started to make improvements in reducing risks to people's safety. The risks to people's health, safety and welfare were now being reassessed, recorded and kept under review. Incident and accident records had been completed or signed off by the senior management to confirm all necessary actions had been taken.

Staff member's knowledge and skills were being reassessed to ensure they had the skills to care for the

people who lived at the home.

The provider's quality assurance systems and processes had started to address issues with documentation, medicines found at our last inspection. Although staff members felt more supported, professionals continued to express mixed views about and varying confidence in the management team.

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 Inadequate [published 15 November 2019].

At this inspection although the provider was making improvements to the areas we identified at the last inspection this needed to continue and evidence provided to show the sustainability of the improvements. The provider continues to be in breach of regulations

We reviewed the information we held about the service. Ratings from previous comprehensive inspections for those Key Questions were used in calculating the overall rating at this inspection. The overall rating for the service has remained the same. We have found evidence that the provider still needs to make improvements. Please see Safe and Well-led sections of this full report.

Follow up
We will continue to monitor the service closely and discuss ongoing concerns with the local authority. 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.

Special Measures
The overall rating for this registered provider is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC. The purpose of special measures is to:
• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide, or we will seek to take further action, for example cancel their registration. 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.

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. We will have contact provider following this report being published to discuss how they will make changes to ensure the service improves their rating to at least Good.

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.

Tithe Barn

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 one inspector and an inspection manager on 30 October 2019.

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

Since our last inspection the service did not have a manager registered with the Care Quality Commission as they had left their post.

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. This information included the previous inspection report and any information or concerns the Care Quality Commission [CQC] had received from the public and professionals since our last inspection. We sought feedback from the local authority and professionals who work with the service. We used all this information to plan our inspection.

During the inspection
We spoke with two people who used the service and two relatives about their experience of the care provided. We spoke with six members of staff including the managing director, operations director, deputy

manage and, support workers.

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at two 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 also reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance action plan reports. We continued to liaise with the local authority, health and social care professionals and the police.

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 Inadequate. At this focused inspection this key question has now remained the same. This was because although we saw the provider had started to make some improvements, however, not enough time had passed to evidence the sustainability of the improvements made.

Systems and processes to safeguard people from the risk of abuse

- At our last inspection we had received concerns regarding aspects of the care and treatment of people who lived in the home. We made the provider aware of our findings and at the time of our inspection these allegations were subject to both external [police] and internal investigations, these are still ongoing.
- Since our last inspection, the provider has ensured the safeguarding concerns have been reported to the local authority and the CQC have received the notifications.
- However, until the investigations are concluded the breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safeguarding service users from abuse and improper treatment remains in place.

- At our last inspection the provider had failed to robustly assess the risks relating to the health, safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found not enough time has passed to provide evidence of the sustainability of the improvements made so the breach in regulation 12 remains in place.

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

- At this inspection we saw risks to people's safety had started to be reassessed and reviewed. Action had been taken by the provider to ensure people remained safe from harm. We saw staff had been asked to complete a "Knowing your service users form" to ensure staff members knew people's individual risks. Although we found not every staff member had completed these information forms for everyone living at the home. We were given assurances from the provider this work was being given priority.

- At our last inspection staff members told us accidents and incidents were not always reported and recorded. They were able to give the inspection team details of incidents and when we checked on the incident records no paperwork could be found. Since our last inspection we had received assurances from the provider that staff had received further training to ensure all accidents and incidents were recorded, giving full details of what had occurred, and any action taken.

Staffing and recruitment

- At our last inspection we found the provider's recruitment processes did not always ensure the suitability of potential staff to care for people.
- Due to the ongoing police and internal investigations, the provider was using a high number of agency

staff to cover shifts. The provider had made arrangements that permanent members of staff were working alongside agency staff, to minimise the disruption to people living at the home. We could not assess the provider's recruitment procedures were now being followed. This was because no new staff had been recruited since our last inspection visit.

Using medicines safely

● At our last inspection we found medicines management was not safe putting people at unnecessary risk.

● Medicine temperatures were not always recorded. At this inspection we found improvements had been made. The operations manager told us staff had received further medication training and staff competencies had been assessed, to ensure they were safe to administer people's medication.

Preventing and controlling infection

● At our last inspection we found the provider had policies and procedures to ensure the home environment was clean and hygienic. However, the provider had not done all that was reasonably practical to reduce risks of infections spreading.

● Although we found at this inspection some action had been taken by the provider we still found used mops and buckets left unattended around the flats for example, on the landing area between flats four and five.

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 Inadequate. At this focused inspection this key question has now remained the same. Although there had been some improvements made, not enough time had passed to allow these systems to be embedded and sustained.

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

At our last inspection we found the provider's quality assurance systems were inadequate. We found people living at the home were not protected and supported to be safe as the registered manager and the provider did not have full oversight of the service. There was a lack of systems and processes in place to effectively monitor and improve the quality and safety of support provided. There were inadequate auditing systems in place to identify and mitigate any risks relating to the health, welfare and safety of people who lived at the home. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Since our last inspection there had been a change of management. The registered manager and operations managers are no longer working at the home. Whilst the provider was in the process of recruiting a new manager, senior managers and experienced managers from the provider's other homes were covering and helping to make improvements. A staff member told us they, appreciated a more stable management structure following lots of changes. Another staff member told us, "I do appreciate [operation director's name] coming over to the flats to see if we are okay?"
- Accidents and incidents were inconsistently recorded and there was no auditing of these records to ensure the appropriate actions were taken and lessons were learnt. Safeguarding concerns were not routinely identified, investigated and reported to the appropriate authorities. Since our last inspection CQC are receiving notifications of any accidents and incidents as required.
- The provider had failed to identify the training needs and competencies of staff to meet the clinical requirements of people living at the home compromising people's safety and welfare. Staff competencies were not always completed to ensure staff were carrying out their role and responsibilities in an appropriate manner. Since our last inspection the provider had reviewed staff members skills and identified further training requirements. Training sessions for staff members had been arranged for example medication administration, and positive behaviour support training.
- The chief operating officer had provided CQC with regular up-dates and progress within the home, which also included shortfalls and training delivered to give staff the skills they needed to support people.

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

- At our last inspection, we discovered the registered provider had not made us aware of all safeguarding concerns and had not submitted the relevant notifications to us. This was a breach of Regulation 18 of the

Care Quality Commission (Registration) Regulations 2009.
● Since our last inspection the provider has ensured notifications were sent to the CQC has required to do so. 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

● Since our last inspection the provider had reviewed people's care plans to ensure they provided staff with accurate information regarding people's individual needs
● The provider had cooperated with social care professionals to ensure people who had moved out of the home were supported with the transition to their new homes.