# The Regard Partnership Limited

# Berkeley House

## 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
Berkeley House is a residential care home providing personal care to 16 people who have learning disabilities or autistic spectrum disorder. The service can support up to 19 people within the four separate houses, The Windmill, The Granary, The Bakery and Pippin.

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

During the inspection, the majority of risks and concerns were identified in the Bakery House. However, other concerns were also found in the Windmill house.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

Right support:
• Model of care and setting did not maximise people's choice, control and independence
People were not always supported to be as independent as possible. A staff member was observed forcing a person into their wheelchair against their wishes. The setting did not maximise people's choice and control, one of the buildings was being decommissioned and therefore people had been given notice to leave.

Right care:
• Care was not person-centred and did not promotes people's dignity, privacy and human Rights
People had not been consistently supported in a person centred and positive way. People's dignity and privacy had not been upheld. One person had no blinds or curtains at their window, their window was also permanently fixed open. People's basic human rights were not upheld as they were unable to access toilet paper, in the Bakery house, on the morning of our inspection.

Right culture:
• Ethos, values, attitudes and behaviours of leaders and care staff did not ensure people using services lead confident, inclusive and empowered lives
The culture within the service was poor. Some staff spoke to people in a degrading manner. People were referred to a 'verbal' and 'non-verbal'. There was a lack of respect from staff and management regarding the environmental aspects of the service. Staff told us that other staff members had been careless with people's

bedroom furniture, and this had caused damage and the furniture had not been replaced. People's bedrooms were dirty and unhygienic.

People living in the Bakery were living in unclean and unsafe conditions. They were not protected from the risk of harm or abuse. Safeguarding incidents had not been consistently recorded or reported to the local authority safeguarding team so they could be investigated.

Risks to people's health were not always identified. No guidance had been provided to staff about how to support people with other risks. Risks relating to the environment had not been mitigated to keep people safe.

The service was not clean. Peoples bedrooms were dirty and unhygienic and posed a risk to their health. Government guidance regarding wearing and disposing of personal protection equipment was not being followed.

There were not enough suitably qualified and experienced staff to support people with their individual care needs.

There had been no review of incidents and accidents and they continued to happen. No trend analysis had been completed and actions had not been to be taken to mitigate future reoccurrence of incidents.

There was a poor culture within the service. Staff were heard speaking to people in a degrading manner. There was a lack of respect for people's dignity and personal belongings.

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.

There was a lack of oversight from senior management regarding quality assurance within the service. Following this inspection, we worked closely with the local authorities to make sure people were safeguarded from ongoing harm. Seven people were supported to move out of the service.

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 requires improvement (published 16 June 2021)

Why we inspected
The inspection was prompted in part due to concerns received by another healthcare professional. The concerns raised were in areas such as poor leadership, poor risk management, people not being kept safe from abuse or harm and people living in poor and unsanitary conditions. A decision was made for us to inspect and examine those risks.

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.

We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to the service not being able to keep people safe from harm or abuse, inadequate risk assessments and guidance for staff surrounding risks to people, insufficient suitably qualified staff, failure to treat people with dignity and respect, failure to follow legal framework for consent to care being provided and failure to effectively monitor the quality of the service at this inspection.

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

Follow up
Following the inspection, we took urgent action to restrict admissions to the service. This meant that people living in The Bakery moved out of the service immediately following our inspection as they were not safe living there. We also took urgent action and required the provider to ensure staff were trained in administering medication to people living with epilepsy. The provider has cancelled their registration of Berkeley House. Everyone has now moved out of the service and Berkeley House is now closed.

## 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.

# Berkeley House

**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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Berkeley house 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. 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. However, the registered manager had submitted a notice to de-register. The service was being overseen by another manager. This manager was a registered manager at another location.

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 who work with the service. 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. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service and one relative about their experience. We spoke with seven members of staff including the regional manager, the manager, senior staff members and support staff. We reviewed a range of records. This included four people's care records and multiple incident 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 reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. However, this was not provided to us.

Inadequate

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm and their basic human rights being met.

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

Preventing and controlling infection

- People living in the Bakery house did not have their basic needs met; they were living in inhumane conditions. People did not have access to basic hygiene products. We found no toilet roll in the bathrooms at the Bakery house, which were used regularly. When this was brought to the attention of a staff member, they told us toilet roll was locked away and they did not have access to the key until the manager arrived on site. Staff were not able to tell us the last time people had access to toilet paper or what people are supposed to use instead. Staff were unable to ensure people could maintain thorough personal hygiene, leading to the risk of spreading infection and their own health deterioration.
- We were not assured the manager and staff were complying with infection, prevention and control guidance. People were living in very poor, dirty and unhygienic conditions. People's bedrooms were not clean, and faeces was found on two people's bedding, pillows and another person's chair. One person's bedroom had a very strong smell of urine. People's bedsheets were dirty, and one person did not have any bedding. Unsanitary living conditions exposed people to the risk of infection and potential health deterioration.
- The service was not complying with current government guidance around the use of personal protection equipment (PPE). We observed some staff not wearing face masks and other staff not wearing face masks correctly. Discarded and used PPE was also found in people's bedrooms and the garden. This should have been stored in secure bins to protect people from the risks of the spread of infection.

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

- People's specific health needs were not always risk assessed and well managed. One person lived with epilepsy and had been prescribed an 'as required medicine' to help control seizure activity. There was no guidance for staff on how or when to use the medicine. Staff we spoke to were not confident to administer the medicine. We were not assured there was a trained member of staff on each shift to administer the medicine. We asked the manager for confirmation of competency checks and training for staff during and following inspection, but this was not provided. When epilepsy is not well managed and controlled it can lead to life changing injury or death.
- The staff and the manager failed to identify and assess the risk around behaviours of distress. Incident and accident forms detailed what behaviours people had displayed when they were anxious or distressed. These behaviours were not identified in the person's care plan. We found there was no guidance in place to inform staff on how to reduce or de-escalate behaviours people may display. The regional manager told us people's personal behavioural support plans were in the process of being created and implemented. Staff told us people were scared of each other and would go to their rooms to hide when other people displayed anxiety and distressed behaviours.

● Care plans did not always detail risks regarding people's individual health needs. One person was at high risk of blood clots. This was not in the persons care plan and there was no guidance for staff to support this person. The person was not able to verbally communicate any health concerns they had and relied on staff for support and knowledge regarding this. When the risk of blood clotting is not managed or monitored it can lead to the person developing complications such as heart failure.
● Some people had risks associated to cleaning products and fluids. Staff did not always follow guidance to keep people safe. In Bakery House everyone's toiletries needed to be locked away in a cupboard. We observed one person toiletries to be left outside of the locked cupboard. When we highlighted this to a staff member, they locked the toiletries away immediately.
● Potential risks from the environment had not been highlighted and rectified. Unsafe flooring in people's bedrooms was a trip hazard. A draw in the kitchen which people used, contained sharp equipment and was not locked as the lock had broken. When we spoke to a member of staff they told us the lock kept breaking. Measures had not been put into place to mitigate the risk to people and staff.
● There was a lack of learning from accidents and incidents at Berkeley House. The manager and regional manager confirmed that they had not implemented a process to analyse incident and accidents. We would expect incident and accident forms to be reviewed by a manager to ensure appropriate action has been taken, to keep people as safe as possible.

The provider had failed to assess the risks to the health and safety of people, doing all that is reasonable practicable to mitigate risks. This was a Breach of Regulation 12 (safe care and treatment) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People were not protected from the risk of harm or abuse. We observed a staff member pushing and forcing a person to sit in their wheelchair against their will. This was immediately reported to a senior member of staff and the manager. However, appropriate action was not taken to safeguard people placing them at continued risk of harm.
● Staff told us about an incident where one person had been violent towards another. This incident had not been documented and action taken to safeguard people from future similar incidents.
● Safeguarding procedures were not always followed correctly. The manager had failed to report a safeguarding incident to the local authority and the Care Quality Commission. Staff had told us about an incident between two people in the service, when we brought this to the attention of the manager, they were unaware of the incident.
● We were not assured staff had adequate and up to date knowledge about safeguarding to keep people safe. Staff told us they had completed their safeguarding training and the had a good understanding of safeguarding. However, we found that staff failed to identify and act upon abuse. During and following the inspection we requested copies of the staff training; however, this was not provided to us.

The provider failed to protected people from abuse and improper treatment. This is a Breach of Regulation 13 (safeguarding service users from abuse and improper treatment) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● There were not always sufficient numbers of suitably skilled and experienced staff on duty. Often there was only one staff who could administer medicines on shift. When the staff member was administering medicines people who needed to be supported by two staff were only supported by one staff member. People were at risk of not safely being supported if they became anxious or distressed.
● We asked to review staff rotas during the inspection and following the inspection, but these were not

produced by the provider therefore we could not be assured people received the support they needed.
● Staff were not suitably trained to meet people's needs and keep people safe. Staff we observed did not interact with people and did not have the skills to engage with people. Staff told us of incidents that happened between two people in the service. Staff knew that one person would retaliate, and staff failed to recognise they have a responsibility to intervene before the situation escalates. Incident reports highlighted when staff had failed to effectively de-escalate the situation when people displayed known anxious and distressed behaviours.

The provider failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff. This was a Breach of Regulation 18 (Staffing) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

● People were supported by staff who were recruited safely. We reviewed two staff members recruitment files. The recruitment checks included previous employment history, explained gaps in previous employment and references.

Using medicines safely
● Audits of medicines were completed. These highlighted errors and actions that needed to be taken. The recent audit highlighted that an 'as required' medicine protocol needed to be updated. This had been actioned and an updated protocol in place.
● Temperature checks were carried out to ensure they medicines were stored safely and in line with best practice.
● We reviewed medicine administration records in Bakery House. A stock count of a persons' medicines matched with the number on the medicine's administration records.

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 requires improvement. 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.

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

- The provider had failed to identify and address the closed culture within the service. A closed culture means a poor culture that can lead to harm, which can include human rights breaches such as abuse. The provider had not addressed the closed culture and this had led to people not being treated with dignity and respect. People did not have curtains at their bedroom windows for their privacy and dignity. Other people were wearing clothes which we too small for them and did not fit them.
- The provider had failed to complete basic checks within the service to ensure people were living in clean and hygienic conditions. The provider had not addressed the infection, prevention and control issues, developing an abusive culture within the service. People's basic human rights were not being met.
- The provider had failed to ensure people were able to achieve good outcomes. People had not been supported to be part of their local community. Staff told us they had lost confidence to take some people out and there were not enough the staff to take other people out. Staff told us this impacted on people's wellbeing and increased incidents of behaviour which challenged staff within the service.
- The provider had failed to ensure there was consistent leadership and role modelling in the service. We observed staff use derogatory language when talking to and about people. One staff member referred to people as 'verbal' and 'nonverbal' rather than using their name and positively describing how they communicated. Staff spoke with people in a harsh tone and were focused on tasks rather than engaging with people to meet their emotional needs. Staff demanded that people kept out of our way and used phrases such as, 'personal space' to usher people away from us, without explanation to people.

The provider failed to ensure people were treated with dignity and respect. This was a Breach of Regulation 10 (dignity and respect) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

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

- The provider failed to ensure that the management team at Berkeley House had sufficient oversight of the service to address any shortfalls. The provider had failed to identify and address that one person's bedroom window was fixed open despite the weather conditions. The decision had not been made in the person's best interest and they had not agreed to this. This left the person at risk of harm during hot or cold weather. The provider had failed to identify and act when peoples' bedroom furniture had been damaged by staff. Staff told us that peoples' furniture had been broken for over three months and no action had been taken to replace or repair it.

● The provider had consistently failed to monitor the service. Care plans and risk assessments had not recently been reviewed or updated including following incidents. Documentation was not accurate and did not reflect people's care needs. For example, one person's health care plan detailed a health condition that they did not have. Serious health conditions had not been detailed in other people's care plans.
● There was a lack of learning and improvement since the last inspection in May 2021. We would have expected the provider to develop an action plan and to have acted to improve the quality of the service and people's lives. The quality of the service had deteriorated, and the provider was not aware of this. Audits and checks by the manager and provider had failed to identify the significant failings of the service highlighted at the inspection.
● During and following the inspection we asked for assurance the provider had completed checks and audits on the quality of the service people received. We did not receive this assurance.

The provider failed to monitor and mitigate the quality of the service and to individual people using the service. This was a Breach of Regulation 17 (Good Governance) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

● Services that provide health and social care to people are required to inform CQC of important events that happen in the service. CQC check that appropriate action has been taken. The provider had failed to submit notifications about allegations of abuse to CQC.

The provider failed to consistently submit notifications of abuse in a timely manner. This was a Breach of Regulation 18 (notification of other incidents) of the Care Quality Commission (Registrations) Regulation 2009

● The provider failed to ensure legislation regarding people's consent and restrictions was complied with. The provider had no oversight of legal documentation that needed to be updated. When deprivation of liberty standards (DOLS) expired for people, new authorisations had not been sought. A DoLS ensures that people who cannot consent to their care arrangements in a care home are protected if those arrangements deprive them of their liberty. People were therefore restricted without any legal authority.
● The provider had not followed legislation in relation to the Mental Capacity Act, when people lacked the capacity to make complex decisions about their care. For example, there were no best interest meetings regarding the COVID-19 vaccine or other restriction placed upon them such as not having access to their toiletries. People were not supported to make decisions and did not have their rights upheld.

The provider failed to ensure that care and treatment was provided with consent. This was a Breach of Regulation 11 (Need for consent) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● The provider failed to ensure people and their relatives were involved in their care and support plans. There was no evidence that people's goals and aspirations were documented. There were no steps on how people can achieve their goals. The provider had made no effort to ensure people's rooms were personalised or homely.
● Action had not been taken to ensure people were able to be involved in the running of the service and make decision about their day to day lives. For example, important documents such as the complaints process were not available in easy read versions. Signage had not been used around the building to support people to move around independently. Pictures were not included on menus to help people make decisions

about what they wanted to eat.

● The provider failed ensure there were positive working relationships with other agencies for people's best outcomes. Health care professionals who visited the service had suggested improvements to better support people, such as putting equipment in place to support people to manage their continence. The manager and provider had not acted on these and people continued to live in poor and unhygienic conditions.

● The regional manager told us they hadn't always worked well with other agencies. They told us that their relationship with various local authorities was "fractious".

● The provider had failed to address the wellbeing of staff and people in the service. Staff morale at the service was low. Staff told us there had been frequent changes in management and until recently they had felt unsupported and not listened to.

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 duty of candour requires providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment.

● The provider failed to be open and transparent with families regarding the closed culture at Berkeley House. The provider had served notice on people living in the Bakery House informing families this was due to the condition of the building and was no longer suited to peoples' needs. However, they had also failed to disclose to families that a poor closed culture had develop in the service putting people at immediate risk of harm and abuse.'

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 18 Registration Regulations 2009 Notifications of other incidents<br><br>The provider failed to consistently submit notifications of abuse in a timely manner. |

**The enforcement action we took:**

We served the registered provider urgent conditions on their registration

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>The provider failed to ensure people were treated with dignity and respect. |

**The enforcement action we took:**

We served the registered provider urgent conditions on their registration

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider failed to ensure that care and treatment was provided with consent. |

**The enforcement action we took:**

We served the registered provider urgent conditions on their registration

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider had failed to assess the risks to the health and safety of people, doing all that is reasonable practicable to mitigate risks. |

**The enforcement action we took:**

We served the registered provider urgent conditions on their registration

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or | Regulation 13 HSCA RA Regulations 2014 |

| | |
|---|---|
| personal care | Safeguarding service users from abuse and improper treatment<br><br>The provider failed to protected people from abuse and improper treatment. |

**The enforcement action we took:**

We served the registered provider urgent conditions on their registration

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider failed to monitor and mitigate the quality of the service and to individual people using the service. |

**The enforcement action we took:**

We served the registered provider urgent conditions on their registration

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff. |

**The enforcement action we took:**

We served the registered provider urgent conditions on their registration