Chartwell Care Services Limited

Barkby Road

Inspection report

220 Barkby Road
Syston
Leicester
Leicestershire
LE7 2AJ

Tel: 01162605088
Website: www.chartwell-care-services-ltd-residential-care-home.business.site/

Date of inspection visit:
30 May 2018
04 June 2018

Date of publication:
31 August 2018

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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

This inspection took place over two days. We arrived unannounced on 30May 2018 and returned announced on 4 June 2018.

At the last inspection on 8 November 2016 we found that the service was meeting the Regulations we looked at.

At this inspection we found the service had deteriorated and rated 'Requires Improvement'. Therefore improvements were needed.

Barkby Road is an 11 bedded purpose built care home for adults with moderate to severe learning disability, complex needs or challenging behaviour. The service also offers a specialist support to those with Autistic spectrum disorders. The accommodation was provided in the main building and in two additional separate buildings within the grounds. At the time of this inspection the separate buildings accommodated three people who had greater levels of need and very high levels of behaviour that challenged. On the day of our visit there were 11 people living at the home.

The registered manager had gone on maternity leave in May 2018. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider had notified us of the alternative management arrangements during this period, which were the operations officer would oversee the service and support the deputy manager in the day to day running of the service.

We found the high use of agency staff working at the service meant staff often lacked the specialist knowledge and skills to care for and support people safely.

Care plans and risk assessments did not always reflect people's current needs as they were not reviewed and updated regularly.

Medicines were being managed safely when we inspected the service, however the temperature of where medicines were stored was not being monitored safely and there was a risk that medicines would exceed the manufactures recommended safe storage limits.

People had a choice of food and drink each day and were given these in sufficient quantities.

Where people had identified activities they wished to participate in they were not always supported with these. This was due to staffing levels at the service. People were not supported to live fulfilling lives and there was a lack of emphasis on people's goals and aspirations. People spent long periods of time with little or nothing to do.

People's dignity was not always maintained. People did not receive the right support to maintain their privacy and dignity.

Staff training was not adequate and not designed to meet the needs of people who used the service. Staff did not feel that they received adequate training and their performance was not being effectively monitored by senior management. We were told by support workers they felt unsupported and under-valued at the service. This was as a result of poor communication and a 'them and us' attitude within the service.

People did not have access to information about the provider's complaints procedure as it was not tailored to the communication and cognitive needs of most people living at Barkby Road.

We found examples of poor management and leadership that impacted on the outcomes for people that used the service. Notification regarding arrangements to cover the operation officer leaving who had been covering the registered manager was only sent to us after we raised concerns with the chief operating manager.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

There were insufficient staff available and deployed appropriately to meet
people's individual needs and keep people safe.

People who required one to one and two to one care were not always getting this which put them and other people using the service at risk.

The service required continuous maintenance to keep it safe and hygienic, this was not always happening.

Risk assessments and care plans were not always reviewed and did not always provide up to date information to ensure people's safety.

Medicines were being managed safely at the service but were not always kept within the manufacturers recommended temperature limits.

Safe recruitment systems were in place; however, references for staff had not always been received by the registered manager.

Staff were aware of their responsibilities of how to keep people safe and report concerns.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not adequately trained and supported in their roles to provide the care people required.

Staff did not feel they had the knowledge to support people safely.

Most people were given a choice of food and drink and were given sufficient quantities. However people were not always consulted on their environment or how they spent their time.

The principles of the mental capacity act had been followed.

People had access to health care services.

Is the service caring?

Requires Improvement

The service was not caring.

Staff did not always deliver care whilst respecting people's dignity and privacy.

Not all support workers employed at the service knew people's individual needs.

People were given opportunities to express their views. However the provider did not always act on this information.

Is the service responsive?

Requires Improvement

The service was not responsive.

People had not always received personalised care. The information about
people's preferences, interests and hobbies and what was important to them
had not always been acted upon.

There was a lack of emphasis on people reaching their potentials and leading fulfilling lives which encouraged and supported their independence.

People's care records were not regularly reviewed with them or their representatives.

The complaints procedure was not written in an accessible format and it was unclear that complaints were acted upon.

Is the service well-led?

Inadequate

The service was not well-led.

Poor and inadequate leadership from the provider meant that the service was not well-led.

Staff did not feel supported and systems were not in place to enable staff to express their views or make suggestions about the management of the service.

There was an lack of trust from staff working within Barkby Road

and senior management of Chartwell Care Services. Communication within the service and between senior management was poor.

Quality monitoring systems were inadequate as they failed to identify or show what action had been taken to improve the service.

Barkby Road

Detailed findings

Background to this inspection

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

This inspection took place on 30 May 2018 and was unannounced. We returned on 4 June 2018 announced to complete the inspection. The inspection was carried out by one inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was in people with a learning disability.

Before our inspection, we reviewed the information we held about the service. We had received information of concern from the local authority and local clinical commission group in relation to the care and wellbeing of people using the service. They have funding responsibility for some people who were using the service. At the time of our inspection there were 11 people living at the service.

The provider did not meet the minimum requirement of completing the Provider Information Return at least once annually. 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 made the judgements in this report.

We were able to speak with five of the people living there. We were unable to speak with more people due to their complex communication needs. We also spoke with the provider's chief operating officer, the operations manager, the deputy manager and four support workers and a team leader.

We observed support being provided in the communal areas of the service. This was so we could understand people's experiences. By observing the care received, we could determine whether or not they were comfortable with the support they were provided with.

We reviewed a range of records about people's care and how the service was managed. This included our people's plans of care. We also looked at associated documents including risk assessments. We looked at

records of meetings, recruitment checks carried out for three support workers and the quality assurance audits the management team had completed. Following the inspection we spoke with the local fire officer as we found concerns regarding fire safety at the service.

Requires Improvement

Is the service safe?

Our findings

People were at risk due to an insufficient number of support staff working at the service. We found that people had complex need. Three people were assessed as needing four additional one to one hours per day. Four people have between five to seven hours of one to one time per day. A person with very complex needs is funded for two to one staff time partially throughout the day. This level of support had been assessed and agreed with the funding authority. Care Services Limited told us that due to the complexity of the person's needs they provide extra support above what the local authority fund.

The support workers we spoke with told us they had concerns about the staffing levels. One support worker told us, "There are usually at least two or three agency staff on each shift. Some are better than others but some just sit there and don't do anything with the residents." During the day we visited there were eight staff on duty, including two agency staff. One person was out in the community and they required two to one support whilst out. Support workers also had to carry out cleaning, laundry and food preparation as part of their role. This meant that support workers were not always available to support people when they needed to be. We also observed periods of time when people were left on thier own. We observed people sitting for long periods of time who were not engaged in any kind of activity due to staffing levels within the service.

On one occasion a person who required one to one support was left alone whilst they were in an anxious state. The person then banged their head against a table, which was a known behaviour for this person. Support staff did intervene shortly after the incident happened. We observed the person had broken skin on their forehead following this incident.

The people using the service had complex conditions; some could display behaviours which may have been challenging. Some support workers were not familiar with people's risks and could not therefore ensure their safety. For example, one support worker told us they were working in one of the bungalows in the grounds of the service with a person who required two to one support. This support worker had only been working at the service for a short time and had limited training to understand the person's complex needs.

Rotas showed that there were times that the service relied heavily on agency staff to ensure there were sufficient staff available. Our observations found that people were not getting the one to one care they needed and that, at times, people were left with little or no support workers, which put them at risk. People were not able to spend their time in the way they would have liked and there were periods of time when people were left sitting on their own doing very little. This was due to staffing levels at the service.

The above evidence indicates a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

Risks to people's health and well-being were not being safely managed at the service as people were not receiving the kind of support they needed. Support workers did not receive adequate training to provide some of the specialist care people needed. Agency staff were being used who lacked any knowledge of people and their complex needs.

Risk assessments did not always provide an accurate and up to date record of people's risks and did not provide enough information for support workers to be able to safely manage people's risks. For example, one person who had very complex needs had not had their risk assessments reviewed since August 2017. This risk assessment did not reflect recent incidents and was therefore not accurate in the information it provided support staff when they supported the person. The person was at on-going risk of unsafe care and treatment due to this.

The above evidence indicates a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

People were receiving their medicines safely. We reviewed records in relation to the administration of people's medicines and found that support workers were administering these safely and as required. Checks were carried out regularly to ensure that people were getting their medicines. Only trained support workers were administering the medicines at the service.

The room where the medicines were stored regularly reached 25C. (Most medicines come with directions from the manufacturer to store below 25C to ensure they remain effective when they are administered.) Support workers told us they had previously been told by the provider they should leave the door to the room and cupboard open to allow the area to cool. This meant a support worker had to stay in the room as people using the service had access to this area and it would be unsafe to leave unattended. We discussed this with the chief operating officer to look at ways of ensuring this area was kept within a recommended temperature range in a safe manner.

Although support workers had a good understanding of their responsibilities to reduce the risk of cross infection and knew to use personal protective equipment, such as gloves and aprons when providing personal care, we found many areas of the home to be unclean. We saw in the kitchen that the pipes at the side of the refrigerator were extremely dirty and dusty. In one person's bedroom we found a pair of used protective gloves on the windowsill. These had been left there for some time due to the discolouration and state of the gloves. In other bedrooms we noted that the light shades, which were not domestic, were dirty with dead insects inside. The bedclothes in one room were dirty and stained. Some bedrooms had strong offensive odours and stained carpets. In one bedroom the carpet was badly stained. We were told that this was caused when the person used the shower, the water overflowed from the shower room. The floor would become very wet and flood into the bedroom area staining the carpet.

The above evidence indicates a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

The conservatory area, which people used as a dining room, was used by support workers as a dumping area for items they did not know what to do with. During our inspection we saw a large sheet of plywood, an old set of drawers, an old bicycle and a person's sensory weighted jacket. All these items could potentially be a hazard. We also saw a similar sheet of plywood in the laundry area. This stuck out beyond the entrance door and again was a potential hazard to people using this area. Vacuum Cleaners were stored behind doors. One of the vacuum cleaners was held together with tape. We were told this was because a person living at the service had damaged it. In one of the bungalows where two people were supported we saw skirting boards were missing and the carpet in the bedroom was very dirty.

Additionally, the fire door leading from the staff room to outside had a broken window. We were told this happened when a person, who is known to self-harm, hit their head against the glass. A temporary repair had been made but we were told that it had been like this for some time. We were shown a copy of the

maintenance list and the need to repair this window did not appear on the list. We raised this with the chief operations officer who told us that a new maintenance list was being worked on.

The staff office where both support workers and people using the service had access to was dirty and there were hazards that were potentially unsafe. There were electric cables which had come away from their housing and were hanging out the conduits. The two office chairs were unsafe as one had a broken seat and the other did not stay at the correct height when sat on.

In one bedroom the bedroom door, which was also a fire door, had a crack down the centre emanating from the lock. This could potentially render the fire door unsafe if a fire were to occur. We brought this to Leicestershire Fire Officer's attention to investigate further.

The service was split into three distinct parts. The main house where most people lived and two small bungalows in the grounds of the service. The maintenance records did not identify areas we had found in need of maintenance. Records also showed that some issues had been ongoing for some time and repairs had not been made until several months after they had been identified. For example, the window in one of the bungalows was broken in August 2017 but not repaired until November 2017. None of the records we looked at showed the premises were being maintained on an on-going basis. Where repairs had been carried out there were done so in a very unsatisfactory manner. For example, on the first-floor corridor there had been a leak and the repair to the ceiling was poor and showed lack of care. Another example, was where door handles had been removed paper was stuffed into the resulting hole. This meant people had been placed at risk.

The above evidence indicates a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Premises and equipment.

The main building was separated from the two buildings at the rear of the property by a secure gate. We were told by support workers that this gate should be locked at all times to prevent people from the two buildings at the rear of the property from entering different parts of the grounds. It was also a known safety risk due to some people's unpredictable behaviours that could be very challenging to support workers and to other people living at the service. We saw support staff on at least four occasions either leave the gate open or deliberately stop the gate from closing behind them. We brought this to the attention of senior support worker who immediately closed and secured it.

Incidents and accidents were recorded but there was limited oversight in relation to these. We looked at the accidents and incidents records over the last three months and found that where incidents had been recorded it was not clear what action was taken to minimise the risk of incidents reoccurring. We discussed this with the chief operating officer who told us they would develop a new form that would clearly show how accidents and incidents were managed and what lessons were learnt.

Most support staff had been safely recruited into the service and they had the required recruitment checks in place. However, we did identify a support worker who did not have any references in place. We raised this with the operations officer who told us that the references may be held at the head office. However no attempt was made to provide us with copies of the references during our inspection.

Support workers understood what procedures should be taken if they suspected or witnessed abuse. This included contacting outside agencies such as the police, CQC and local authority safeguarding teams.

Requires Improvement

Is the service effective?

Our findings

Support workers did not have the required knowledge, skills and experience to deliver effective care and support to people and this was due to a lack of training being delivered by the provider. Many of the people who used the service had complex needs and conditions which required support workers to be trained in managing their behaviours and adopting techniques should people become physically or verbally challenging. Although staff were receiving training in some key areas of safe care delivery, such as moving and handling training, we were told most of the training had moved to on-line course. Most staff we spoke with did not feel this equipped them to support people with such complex needs. One support worker told us, "I have asked for medication training, but I've no idea when I will get it." They went on to explain, "I was on shift and there was no one trained to give medicines. A team leader had to be brought in just to give the medicines."

Support workers we spoke with described needing to monitor people to keep them safe and described instances when people had become verbally and physically challenging. We asked support workers whether they were trained in managing these behaviours and whether they had been trained in any form of restraint. Support workers told us although they had received training they did not always feel they had the skills or knowledge to support people where people's behaviour were particularly challenging. We saw support workers had received training in 'Breakaway'. This training helps staff develop techniques to breakaway or disengage from behaviours and move to a safe area. A support worker told us, "They are very good here at stopping behaviours but not proactive in preventing them." This was confirmed by the local authority who told us they received a high number of reports of restraint. This showed that staff did not have the skills to manage people's behaviour by distracting them.

Support workers also told us they did not think handover was very good and they did not always get key information about people's behaviours during the previous shift. This meant support workers could not be effective and put themselves and people using the service at risk of harm as they did not have the knowledge or skills to support the people using the service.

Most of the support workers we spoke with described feeling unsupported. One support worker told us, "(Deputy manager) does their best, but we haven't had supervision or team meetings in ages. I spoke with (deputy manager) to raise some of my concerns but nothing seems to have changed as a result." Another support worker said, "I haven't had supervision in ages." We found no evidence that support workers were receiving supervision. The deputy manager told us they planned to do supervision soon but had been busy trying to make the identified improvements required by the local authority. We did not see any evidence that regular staff meetings were taking place and so support workers were not being given an opportunity to be listened to or raise issues they felt important.

Support workers gave us mixed opinions about the induction they received when they first started. Some support workers told us the induction and training prepared them for their role and responsibilities. However, most said that the induction did not prepare them for their role in providing support to people with complex and challenging needs. They did not feel they received enough shifts where they shadowed

more experienced support workers before being expected to work with people with the most challenging behaviours. Comments included, "No one checks you are competent." And, "I shadowed for four days but not in the cottages. The training was ok." Support workers told us they had not received any developmental training (training to further their knowledge and understanding of their role). The training they had received was all on line. We were told that training was not discussed in supervision and one support worker told us, "We watch a video and answer some questions. No one checks we know what we understand. We don't get any specialist training to work with [person] who has the most complex needs."

The above evidence indicates a breach of Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

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 less restrictive as possible. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The provider had made suitable DoLS applications to the relevant authorities and people had been subject to these safeguards where appropriate. Staff gave examples of how they gained consent with day to day decisions, such as asking people what they wanted to eat. However, we were also given examples where people were not involved in decision making. For example, one person told us that they had not been involved in choosing the colours for their bedroom when it was painted. However, following the inspection the provider sent us information to show that some people had been involved in choosing the colours for their bedrooms to be decorated in.

Although people's care needs had been assessed, we saw little evidence of reviews of these which considered current legislation, standards and best practice in the delivery of care and support to people with the complex needs. Care plans and risk assessments were not always reflective of people's current needs, choices and risks. The provider had not fully considered how people may have chosen to live their lives at the service. This was also brought to our attention following the local authority and local clinical commissioning group (CCG) visits. They told us care plans were not fully reviewed or updated, and there was no evidence of comprehensive behaviour management plans and de-escalation strategies being recorded. We were told by the deputy manager that work had started on addressing these short falls but were not yet completed.

Some people had specific dietary and nutritional needs. We saw the service had made referrals and worked with health care professionals such as a GP and dietician when concerns were identified with people's weight and nutritional needs. One support worker could describe in detail how one person was supported with their diet and how to ensure they received the nutrition they needed. However, when we asked another support worker if there was anyone with special dietary needs they told us "No". We were told that people were encouraged to choose healthy meals but there were no records showing how people were involved in choosing menus. One support worker told us, "People aren't encouraged to help prepare meals." During the day when support workers were preparing the evening meal we saw people huddled around the kitchen door watching staff but did not go into the kitchen.

We did note that the people who lived in the grounds did not appear to be offered a choice. This was confirmed by a support worker who said, "Someone comes over from the bungalow for [person] and gets

their meal. I don't think they are offered a choice."

It has been recommended by the Government that a 'health action plan' should be developed for people with learning disabilities. This holds information about the person's health needs, the professionals who support those needs, and their various appointments. Whilst we found people had health action plans, the sample of three that we saw had not been fully completed and not all reviewed. Whilst staff told us people were supported to access health services to support and maintain people's health, best practice guidance had not been followed. The local CCG had raised concerns that there was no evidence of physical health needs being monitored, reviewed or recorded.

Requires Improvement

Is the service caring?

Our findings

People were not treated with respect and compassion by the provider. Staff told us some people had previously gone out into the community but this was no longer happening. For example, a person who had and been supported to have a voluntary job no longer did this. Staff told us this was because there were not enough support workers to support the person to get there.

People were not having their privacy or dignity respected. For example, during the inspection visit a person who had been supported to have a shower entered a room naked where we were talking with staff. The support worker who followed the person made no attempt to cover the person's nakedness to maintain their dignity. A support worker told us, "Team leaders shout across the room to tell people their medicines are ready. I don't know why they can't be kept in their bedrooms." This was a further example of people not being treated with respect and dignity

A person who lives in one of the bungalows, who prefers not to wear clothes was regularly seen outside the bungalow unclothed. We were told there was a privacy film over the windows. However, on closer inspection we saw that the film was not on all windows and was actually the blue film that comes on new windows to protect them in transit. This person's privacy and dignity was not being maintained. We also overheard a supporter worker describe the person, "This [person] is insane." This was not respectful or promoting the person's dignity.

Whilst senior support workers told us they had responsibility of delegating tasks and directing staff, there was a lack of planning around personalised care. A support worker told us, "[Person] is supposed to go out on Mondays. For some reason they didn't go out on a particular Monday. I was told it was because it was a bank holiday but they do go out on bank holidays. Another team leader told me they could go out if all the staff turn up, whilst another one told me it was as a punishment for their behaviour a few days earlier. It's really poor communication. I feel the team leaders are not working as a team." We were also told by a support worker, they had been in the kitchen with a person making a hot drink when other staff suddenly surrounded the person saying they should not have been in there. When the support worker enquired as to the reason why, they were told it was to do with knives being out. The support worker said, "I understand why knives may be an issue but it was the way it was done. If they had told me first I could have avoided going in or handled it. Rather they were aggressive and made the person feel they had done something wrong."

We observed an agency staff who appeared to be asleep. A person, who liked touching things, stroked the agency staff's head, as they had braided hair and this would have been an interesting tactile experience for the person. Another agency worker said, "Naughty" and proceeded to tell the person off. We brought this to the operations officer's attention. They went to speak with the staff in question.

We were also told that sometimes the rota was not managed well. For example, one person who had the most challenging needs and required particular support workers to provide care, had all their preferred support workers on annual leave at the same time. This meant they were then supported by support

workers who had less knowledge of managing their behaviours placing the person and support workers at risk.

People's views about the service were not sought and there were no arrangements in place to enable people to express their views about their care and support. People were not actively involved in reviewing their care plans. One person showed us their room and told us they were unhappy with the state of decoration, they also told us they wanted a shed. We saw no evidence these issues had been addressed with the person, including whether it was feasible for them to have a shed in the grounds of the service.

The above evidence indicates a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care.

In the main lounge we noticed that one of the sofas was badly damaged with the stuffing hanging out. We were told that a person who was very tactile had found a thread and kept pulling at it until the stitching had all come lose. Staff did not know when the sofa was likely to be replaced nor if people would be involved in choosing a new sofa.

Visitors were welcome at the service and could visit when they chose to. People could spend time with their relatives in their rooms or within the communal areas of the home.

Requires Improvement

Is the service responsive?

Our findings

People's needs were assessed prior to them starting to use the service. Most people had been living at Barkby Road for many years and so any care plans and records had been carried forward from their original assessment. There was a lack of involvement from people and their representatives in on-going reviews and assessments of their care needs and care records did not always reflect people's current risks. For example, not all plans we viewed of people whose behaviours may have been challenging for support workers to manage had been reviewed and risk assessments updated to safely manage this. The care records and assessments did not always reflect how people lived their lives at the time of our inspection. For example, where people no longer took part in community activities.

The local authority and the local CCG had both visited the service and had raised their concerns regarding the quality and lack of up to date information in the support plans. They told us they found support plans were not person centred and did not involve people using the service or their families.

We saw people had 'Person Centred Plans' (PCPs). Person centred planning is a way of helping someone to plan their life and support, focusing on what's important to them. The three PCPs we looked at were not all the same standard and some lacked detail. This meant staff did not have information about people's preferences, routines or what was important to them. As the service used agency staff this meant they may not have the relevant information about what was important to people.

People did not receive care and support that was personalised to meet their individual needs. There was little emphasis on people's individual goals and aspirations and a lack of focus on people achieving their potential. Care and support was provided as and when support workers were available to do so and due to staffing levels. Often people were left for long periods with little or nothing to occupy them. Support workers who had worked at the service for some time understood people's needs; however, they told us they often lacked the time to spend with people.

The CCG had raised their concern with CQC that there was no evidence of activities being undertaken or documented. We raised our concerns with the chief operating manager about people's inactivity and people seemed to have little to occupy them apart from when support workers took them out. The provider lacked an understanding of the complexities of people's needs and the importance of people being able to lead fulfilling lives which enabled them to reach their full potential. The provider did not display a compassionate and caring approach to people using the service and this was evident in the way in which the service was operating.

Support workers we observed were busy in their work which meant they were unable to engage with people fully or as they may have liked. Some support workers we spoke with had worked at the service for many years and knew people well and understood how to best communicate with them. They could describe people's likes and dislikes and tried to engage people in activities they enjoyed when they had the time. However, several support workers described a deterioration in the quality of care and support they could provide and attributed the high use of agency staff.

We were told one person could become anxious when the environment was over stimulating. We were told that there were plans to create a quiet area for this person to use when they became anxious. We were shown the room, it was being used as a general store room with filing cabinets and old furniture. There was a lot of people's clothes in wash baskets as well as one person's wardrobe and chest of drawers. We were told the person whose wardrobe it was could not have their wardrobe in their bedroom as this would make them anxious. Support workers did not know when the quiet room was going to be created nor where the person's clothes would be stored once the room changed use. Plans were not being developed to look at how people's needs would be met when the use of the room changed.

People's independence was not being promoted. Although some people could go out into the community with support, this did not happen for everybody due to staffing constraints. For example, on the first day of the inspection people who had planned to go out were unable to do so due to a shortage of staff. A support worker said, "If we have the staff people can go out to the shops or for meals. I'm not sure what activities if anything take place in the home."

Throughout the day there were periods of time when people were left unsupported, including people who were supposed to be supported on a one to one basis. We also observed the person who lived in the bungalow, who required two to one support on occasions being left with one support worker when the other support worker came to the main building for something.

The above evidence indicates a breach of Regulation 9 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care.

Organisations that provide publicly-funded adult social care are legally required to follow the Accessible Information Standard (AIS) which says services should identify record, flag, share and meet information and communication support needs of people with a disability, impairment or sensory loss. We found information was not always provided in an accessible format. For example, the complaints procedure for people was not in an accessible format and menu choices were not in a picture format.

We were told by the operations officer that complaints were dealt with centrally and they were not aware of the outcomes. We were shown a recent quality assurance survey carried out by the provider in the last 12 months. We saw that some comments were complaints. For example, one relative raised concerns that their loved one sometimes wore other people's clothes. We saw no evidence that this had been addressed and what action had been taken to reduce the risk of people wearing other people's clothes. A support worker told us that all clothes were routinely washed together and no attempt to separate peoples clothes out was made.

There were resident's meetings held at varying intervals throughout the year. People could discuss what activities they wanted to do as well healthy eating. At the last meeting in April 2018 they discussed placing CCTV (close circuit television) in the communal areas. Some people were not happy about it being used others did not mind. During the inspection we did not see that CCTV was in use in the communal areas.

Inadequate

Is the service well-led?

Our findings

Support workers were not being adequately supported which resulted in care and support not being delivered safely and effectively. We spoke with support workers during our inspection to find out whether they felt they could approach senior management should they need to. Most of the support workers we spoke with did not feel supported in their roles. One support worker told us, "We don't have team meetings and we don't have supervision." Another support worker said, "Communication is not good here. We never get told anything. We only know the operations officer is leaving tomorrow because someone overheard (operations officer) mention it would be their last day tomorrow."

Support workers lacked confidence in the provider and in the senior management at the service and felt they were unable to express their concerns. A support worker told us, "I feel some of the team leaders are not good at their job. They don't know how to run a shift well. I'm not sure I would be listened to." We found staffing was not managed well which meant people did not always receive the care and support when they needed it.

During our inspection we found an unsupportive environment where staff were doing their best to care for people in a service which lacked any senior management support to do this effectively. A support worker commented, "There is a real lack of communication here. Handovers are poor. There's layers of management, team leader, senior then support workers. That causes a barrier for passing on information to the manager. We are then not given information about people's needs." Another support worker said when commenting about senior management, "There is a real 'them and us' feel here. We often have no idea who staff are at the head office."

The registered manager was on maternity leave at the time of the inspection. The provider had told us what arrangements were in place to manage the service during this time, which was the operations officer would be overseeing the service and supporting the deputy manager. The CCG told us prior to our inspection, the operations officer would be leaving at the end of May 2018. The provider had not told us how the service would be managed following the operations officer's departure. During our inspection we spoke with the chief operations manager and asked them what arrangements would be in place for the safe management of the service. Following this discussion, we received a notification telling us what arrangements would be put in place.

We asked to see how the premises were maintained and who was responsible for this. We were told the provider employed one maintenance person who also was responsible for the maintenance of the other locations within the group. As a result, ongoing maintenance such as garden maintenance was not carried out in a timely way. The provider would also employ people to carry out certain maintenance tasks. For example, painting and decorating and major repairs. This had led to poor maintenance of the building and unsightly repairs. We were shown the maintenance logs and premises checks. These did not identify all the maintenance issues we had identified during our inspection. The premises were not being safely and adequately maintained due to the lack of regular checks and maintenance work.

We found that the quality assurance systems had not always identified where improvements and actions were required to ensure quality and safety. For example, they had not identified and acted on the shortfalls in supporting staff through induction training and reflection on their practice and development needs. They had not identified where some care plans had not been reviewed and updated to reflect people's changing needs. Where things had been identified, such as lack of supervision for support workers no action was taken to make improvements.

Not all support workers were clear as to the aims and objectives of the provider. Two staff members felt the quality of care delivery had declined since the previous registered manager and deputy manager had left. They did not feel that people using the service were receiving the kind of care to keep them safe and support to enable them to do live full and active lives. People were not engaged in activities during our inspection and the use of agency staff determined what people were and were not able to do. One support worker told us, "I do think things are beginning to turn a corner. It was really bad when the (previous registered manager) left then the deputy left. A lot of staff left at that time. I think if you had come to inspect later this year things would have been better."

Due to lack of formal staff meetings, supervision and appraisals, staff were not being given opportunities to reflect on practice or make suggestions on how to improve the service. One support worker told us, "We don't have formal supervision, we don't get feedback on performance or have opportunities to bring ideas forward."

The above evidence indicates a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

The provider is required to display the rating following CQC inspections, both within the service and where applicable on their web profile, Chartwell Trust displayed their rating on their webpage.

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 were not being provided with the care and support they had been assessed as needing. People were not provided with support that reflected their preferences. People had not always been involved in the planning of their care and people were not provided with individualised or personalised care. This resulted in people not receiving the care and support they needed. This impacted on people's quality of life.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Whilst people were receiving their medicines they were not always stored at the correct temperature. Due to low staff numbers people did not always receive their support in a safe manner. It had been recognised that one person needed a low stimulus environment but no action had been taken to create such a place for them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises were in a poor condition and cleanliness was poor. There were safety risks to people when accessing the outdoor spaces and areas of the service were dirty. Equipment such as vacuum cleaners were left out where people

could access them and potentially harm themselves. People were at risk of injury should they access certain outdoor spaces. The premises had not been maintained adequately and where repairs had been made these were of poor quality. Large ply-wood sheets were left in both the lounge and the laundry area creating potential injury risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were unable to spend any meaningful time with people during the course of the day because of the deployment of staff. Some people required one to one and two to one support. There were significant amounts of time where people were left on their own with no staff support. People were not always able to access meaningful activities that were important to them due to the numbers and deployment of staff. This impacted on people's quality of life. The staff team were expected to complete additional tasks such as cleaning which diverted their time away from supporting people using the service. Not all staff had received the required training particularly with regard to specific health conditions and it was not clear how their competency had been checked or whether it had been checked at all.