Barkat House

Barkat House Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Barkat House Residential Home is a residential care home providing personal care for up to 27 people. At the time of the inspection the service was supporting 24 people.

The care home accommodates people over two floors which are accessed by a lift in one adapted building. It provides care to older people, some of whom are living with dementia and mental health needs.

People's experience of using this service and what we found
Although people told us they were happy and relatives thought people were safe, we found that systems and processes to safeguarding people from abuse were not effective. We observed some poor practice regarding medicine administration and infection control at the home.

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 needs of people with dementia were not fully considered, however further 'dementia friendly' decoration of the service was planned.

We saw some improvements had been made to the environment at the home since our last inspection and some care plans had been updated. However, people's choices and preferences weren't always explored or followed. For example, people's end of life wishes were not always sought. We saw a lack of person-centred activities or meaningful interactions between people and staff.

The registered provider had not ensured there were robust systems in place to keep people safe and meet their needs in a person-centred way. Following our last inspection, the provider had not implemented the improvements in systems and processes required. There continued to be a lack of oversight regarding potential safeguarding matters and feedback from people.

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

Rating at last inspection (and update)
The last rating for this service was requires improvement (published 25 June 2020) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations. This service has been rated requires improvement for the last three consecutive inspections.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 14 January 2020. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show

what they would do and by when to improve person-centred care, need for consent, safe care and treatment and good governance.

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

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 coronavirus and other infection outbreaks effectively.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has remained requires improvement. This is based on the findings at this inspection. 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 Barkat House Residential Home on our website at www.cqc.org.uk.

Enforcement
We have identified continued breaches in relation to safe care and treatment, person-centred care, seeking consent for people's care and how the service is managed at this inspection. 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. As there are already positive conditions in place following our last inspection, these will remain and we will continue to monitor the service. Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures:
The overall rating for this service is 'Requires improvement'. However, we are placing the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any Key Question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect to check for significant improvements.

If the provider has not made enough improvement and there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than

12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Barkat House Residential Home

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 team consisted of two inspectors and an assistant inspector.

Service and service type
Barkat House Residential Home 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 did not have a manager registered with the Care Quality Commission. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because we needed to establish the current status of residents and staff members in relation to COVID-19.

What we did before the inspection

We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We also reviewed information shared with CQC by the provider as part of the requirements following the previous inspection.

We sought feedback from the Local Authority, professionals who work with the service and Healthwatch. Healthwatch is an independent consumer champion that gathered and represents the views of the public about health and social care services in England. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with seven people who used the service and three relatives about their experience of the care provided. We spoke with 10 members of staff including the provider, acting manager, care manager, senior care workers, care workers. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at a staff file in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. The provider took immediate steps to address the concerns found during the inspection.

Requires Improvement

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 requires improvement. At this inspection this key question has now remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse; Assessing risk, safety monitoring and management

At the last inspection the provider had failed to ensure care and treatment was provided in a safe way. This placed people at risk of harm. 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 saw that:

● People were not always protected from abuse. At the previous inspection we found potential safeguarding matters had not always been identified, escalated or investigated by relevant external agencies. During this recent inspection we again identified potential safeguarding matters that had not been escalated or investigated.
●The manager did not always mitigate known risks in relation to people's behaviour. Following incidents of behaviour that challenges, a person's care plans and risk assessments weren't updated. This meant that staff were not provided with enough guidance on how best to support the person. The provider has said they will contact the community team to put together a behaviour support plan for the person.
● The environment was not always safe for people. We found a window restrictor in a person's bedroom was not effective and a fire door that wouldn't close. The provider has now taken action to rectify these issues.
● At the previous inspection we found there was no system, records or audits in place to monitor and mitigate any identified food hygiene risks. During this inspection we found that an action plan had been put in place and regular kitchen audits were carried out. We saw the kitchen was clean and tidy with separate storage space for food required as part of a specialist diet. However, we found food in fridges was not always covered or labelled.
● At our last inspection, we were concerned there was a continued access and security risk between the home and some privately-owned flats. We also found significant fire risks in the communal garden area. At this inspection, the provider had installed a high fence and gate to the garden area. The provider had also cleared the area and put metal ashtrays in place. This meant that people could enjoy the outdoor space safely.
● People told us they were happy at the home and relatives thought people were safe. One person told us what they would do if they didn't feel safe. They said, "I'd just tell them. They'd come and see me."

Enough improvements had not been made in regard to safety. Therefore, the provider is still in breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely; Preventing and controlling infection

At the last inspection the provider had failed to ensure care and treatment was provided in a safe way. This placed people at risk of harm. 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 saw that:

● People received their prescribed treatment correctly and medication stocks corresponded with the records kept at the home. However, we found that safe practices were not always followed. We observed a carer directly handling people's medications without changing their gloves. This meant there was an increased risk of cross-contamination or the spread of infection.
● The medicine trolley was not routinely temperature checked. This meant that medications that were sensitive to temperature changes could have been affected. The provider has stated that temperature checks of the trolley will now take place.
● People were not always adequately protected from the spread of infection. The provider was not following government guidance for care homes regarding self-isolation after contact with someone with COVID-19. This increased the risk of an infection outbreak at the home.
● Robust measures were not always in place to reduce the spread of infection. Staff were not always using personal protective equipment in line with guidance. We found that areas of the building regularly touched by staff and people, such as handrails, were not included in the cleaning schedules.
● The home had some measures in place for the event of an infection outbreak. There had been no positive cases of COVID-19 for people at the home. The manager showed us a vacant room which had been designated as an isolation room to be used if a person tested positive for COVID-19. However, the home did not have a COVID-19 contingency plan in place for how to manage a wide-spread outbreak of infection.

Enough improvements had not been made in regard to safety. Therefore, the provider is still in breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● People and relatives told us there were enough staff to meet people's needs. During our inspection we observed that there were staff available to support people with care needs. One relative told us, "Most of the time there are enough staff when I visited. They do take care of everyone."
● Staff were recruited safely in line with requirements. A staff file we viewed showed the staff member had been recruited appropriately and an induction programme had been completed. However, recruitment records were not always thoroughly completed.

Learning lessons when things go wrong
● At the previous inspection, we found that incidents were not always appropriately reviewed, escalated and learned from. During this inspection records showed that after one person experienced a number of falls, they were risk assessed and referred to the doctor for review. However, the home was still not always aware of trends which were present and therefore actions were not always taken to prevent further incidents taking place.

Requires Improvement

Is the service effective?

Our findings

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

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

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

At our last inspection the provider was not ensuring that people's rights were protected. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At the last inspection, we found that one person's records showed that their relative had signed consent forms. There was no assessment in place to determine the person had not got the capacity to consent themselves. During this inspection we also found records where relatives had signed on behalf of people where there was no evidence that they had the legal authority to do so. This meant that decisions may not have always been made in people's best interests where they lacked capacity to consent to their own care and support.
● The MCA framework was not always complied with. We found two files where relatives were recorded as having a Lasting Power of Attorney for their loved one's health and welfare. This meant they could legally make decisions on behalf of their relative about their care and treatment. However, records did not confirm this status and the manager was unable to evidence that they had made relevant checks to ensure this authority was in place.
● People were not always consulted when they had capacity to make their own decisions. One person's records showed they had been assessed to have capacity to consent about any restrictions on their liberty at the home. However, care plans did not reflect this and the manager could not evidence that the person

had been asked about their wishes.

Enough improvements had not been made in regard to ensuring people's rights were protected. Therefore, the provider is still in breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The correct procedures were followed when people were deprived of their liberty. The home had sought authorisation from the Supervisory Body for people who lacked capacity to consent to any restrictions on their liberty at the home. There was a system in place to ensure these were renewed before they expired.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Adapting service, design, decoration to meet people's needs

● People's individual needs were not always clearly assessed or reviewed to remain effective. We found contradictions in care plans for one person's pressure relief needs and gaps in daily recording. Another person with behaviour needs did not have their care reviewed or clear plans for how best to support their emotional needs.

● People's health needs were not always monitored effectively. The home had not followed up on the results of one person's health monitoring. This meant they were not aware of whether an action was required to manage the person's healthcare condition.

● At the last inspection we found that people living with dementia had a poor quality of care and poor outcomes. There was little for people to find to enable them to engage in independent activity, a lack of sensory and tactile objects and a lack of signage to help people to orientate to time and place. During this inspection we found that some improvements had been made to the environment such as photographs on people's doors. However, signage was not always clear and further decoration works had been delayed due to COVID-19.

● Tactile objects had been purchased by the service but were not available on the day of inspection. The manager told us these were kept in a box in the activity room and therefore were not readily available to people with dementia. The provider told us they would move the objects to encourage people to use them.

After our last inspection, we recommended that the service explored the relevant guidance on how to make environments more 'dementia friendly' and how to provide meaningful stimulation to people who live with dementia. Whilst some improvements have taken place, further work is needed in this area to ensure that the environment is dementia friendly.

Staff support: induction, training, skills and experience

● Staff training was not always completed or updated as required. Records showed that not all staff had up to date safeguarding training. The manager told us this was due to the impact of COVID-19.

● Areas of training that would support people's specific needs, such as challenging behaviour or pressure area care had not been completed or updated for any staff members. However, staff we spoke to were able to describe how they supported people who had particular needs.

● Many staff were multilingual and able to meet people's individual communication needs. We observed staff communicating with people in their first languages.

Supporting people to eat and drink enough to maintain a balanced diet

● At the last inspection we found that mealtimes were not a positive and pleasant experience for people. Staff were task focused and missed opportunities to interact with people. At this inspection we found that some people were sat in the dining room for a prolonged period without much meaningful interaction. We also saw that staff focussed on tasks and missed the opportunity to interact with people.

● People did not always receive the support needed to eat and drink enough. We observed a person who received breakfast and was intermittently encouraged to eat by staff passing through the dining room during the morning. This meant that the person did not receive the individual attention they needed to encourage them with their meal.
● People told us they enjoyed the food. One person said, "The food is beautiful. I never used to enjoy salads until I came here."
● The home had a varied menu to cover a range of dietary requirements and people were given choice. We observed a kitchen staff member asking people individually what they would like from the menu. At lunchtime people could tell us what they had chosen.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● External support was sought for people when their health needs had increased or changed. We saw evidence that referrals were made to healthcare agencies when people needed them.
● Staff were able to tell us when they would escalate concerns about a person's health or when extra monitoring may be needed. One carer told us, "Us carers will see their plates, we will see if they are not eating and monitor this and report to the senior. The senior will report this to the manager and the manager will report it to the GP."
● People were supported to attend regular health appointments. For example, one person's records showed they had seen an optician annually.
● People's oral care needs were met by the service. People had oral health care plans in place and staff were able to tell us about individual people's needs. One relative told us their loved one's oral health had improved since moving to the home and they were no longer experiencing dental pain.

Requires Improvement

Is the service responsive?

Our findings

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

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

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them; End of life care and support

At our last inspection the provider had failed to implement robust processes to ensure care was personalised and able to meet people's needs effectively. This demonstrated a breach of Regulation 9 (Person-centred care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At the last inspection we found people could not be confident their wishes during their final days and following death would be understood and followed by staff. The service had not explored people's preferences, choices, cultural or spiritual needs in relation to their end of life care. Some people who lived at the home had strong faith and religious needs and may have had specific end of life wishes. However, this had not been recorded in their care plan. During this inspection we found some improvements but there were still some people's end of life care plans had still not been explored with people and relatives.
● People's preferences were not always followed. One person's care plan identified they needed support with weight loss and healthy choices. Daily records and our observations showed that the person was not always encouraged with exercise or healthy choices.
● People's dignity and confidentiality wasn't always respected. During our inspection we heard a staff member discussing people's personal health information over the phone, in the presence of other residents. We observed staff referring to people as 'good girl'. Whilst the interactions were caring, this could have been undignified for people.
● At the last inspection we found that people did not always receive care that reflected their needs. During this inspection we found activities were not always person centred and there was a lack of meaningful interaction between staff and people. Where people were able to independently engage in activities, there were facilities available such as a pool table. However, where people required staff support there was little interaction. We observed a group game of snakes and ladders in the lounge, however we did not observe any other activities and people were unable to tell us about other activities they took part in.
● One person's care plan identified they liked to watch television in their first language. When we asked the person if this was available to them, they told us that the television was broken. Another relative told us the home has different televisions to show Asian channels, children's television and general television.

Enough improvements in regard to person-centred care. Therefore, the provider is still in breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

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

● Information was not always presented in a way that was accessible. For example, whilst we found that one person's care plans had been translated into their first language, another person's plans hadn't. This meant that people may not always have been fully involved in their care and support.

● One relative told us the home does a lot for their loved one's accessibility. They told us, "[Relative] has difficulty communicating verbally so the home use word and prompt cards so she can point to what she needs."

Improving care quality in response to complaints or concerns

● Complaints and feedback from people were not always acted on. The manager was unable to explain what action had been taken after one person made a complaint. A feedback form from a person expressing dissatisfaction with the service had not been read.

● One relative told us they sometimes had to prompt staff to support their loved one with nail care. They told us, "Not always, but sometimes I have had to ask about it and they've done it. It should be regular though, I shouldn't have to remind them."

● The complaints procedure was accessible in different formats, such as a range of community languages, and was displayed in communal areas. This meant that people and relatives, for whom English was a second language, had access to the complaints process.

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 inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection the provider failed to operate effective systems and processes to assess, monitor and improve the quality and safety of the service. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Systems and processes in place were not effective in highlighting or preventing shortfalls in the service. Since the last inspection, the manager and the provider have engaged in regular communication with us to discuss the improvements being made. However, during this inspection we found areas of concern that weren't identified as part of the home's audit process.
- The manager lacked understanding of safeguarding processes and the provider had no oversight of the concerns. The provider's systems and processes were not fully embedded to protect people from potential abuse and to recognise when safeguarding referrals needed to be made.
- There was no system in place to review incidents and accidents and ensure safeguarding had been raised where appropriate. There was no overall analysis of incidents to reduce further risk to people.
- Systems in place to monitor care plans were not effective. This meant people's health needs, such as nutrition or diabetes were not always adequately reviewed. Monitoring of the use of Mental Capacity Act was also inadequate and the manager lacked knowledge about how the framework effected people's individual circumstances.
- The monitoring of infection control practices was ineffective and systems did not identify poor practice in relation to the use of personal protective equipment, medicines administration or confidentiality.
- Systems and audits in place to monitor the health and safety of the environment were not always robust. There was no record to show if action identified had or had not been achieved. The provider was aware of actions taken but had not recorded these or communicated them to the manager.

Enough improvements had not been made in regard to systems and processes to drive the quality and safety of the service. Therefore, the provider is still in breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The system in place to monitor feedback and complaints from people was not robust. This meant that views shared by people using the service were not reviewed in a timely way and actions taken were unclear.
● Staff held differing views about whether they could approach the management team with concerns. One staff member spoke highly of the provider and management team. Another told us they didn't find the manager approachable. This meant they didn't feel able to raise concerns with the manager as they weren't confident any action would be taken.
● Relatives told us they had been kept updated on how their loved ones were. One relative said, "The care plan was completed together and if there are any changes the care home contact me and I sign off the changes."
● Staff understood the service's vision and reported recent improvements in person-centred care. Staff members told us the management team had implemented changes to the paperwork kept and completed. This meant that carers had a better understanding of people's needs.

Working in partnership with others; Continuous learning and improving care
● Audit processes which highlighted training needs for staff had not always been acted on. The manager informed us that safeguarding training had been impacted by COVID-19. However, there were some areas of training that had not been covered by all staff.
●Systems were in place to ensure people could access external services as needed. We saw records showing people had been reviewed by the GP or referred to health services due to their needs.
● Staff reported there had been some improvements since the last inspection. One staff member said, "We have extra paperwork we haven't done before. It helps [us] to understand the people who live at the service better."

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 provider understood their responsibility in relation to duty of candour.
● There has been no registered manager in post at the service since July 2019. At the time of our inspection, the manager had put in an application to registered with us. However, the provider has since informed us that this application will be withdrawn.

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 11 HSCA RA Regulations 2014 Need for consent Consent was not always sought from people using the service.