Chartwell Care Services Limited

Barkby Road

Inspection report

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30 October 2018
26 November 2018

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected Barkby Road on 29 October 2018 unannounced and returned announced on 30 October 2018. Due to further information of concern being received we returned unannounced on 26 November 2018. At our last comprehensive inspection on 30 May 2018 rated the service as Requires Improvement overall. The provider was in breach of five regulation, relating to per-son centred care, safe care and treatment, staffing levels, premises and equipment and good governance. The provider was required to submit action plans demonstrating how they were to achieve compliance with the regulations.

At this inspection we found the service had made some of the required improvements. However, we found continued breaches in all five regulations.

Barkby Road is registered to provide residential and personal care for up to 11 people. Nine people are accommodated in the main house, three people live in two bungalows in the grounds of the service. At the time of this inspection there were 11 people living in the service. There were people using the service who could not always express their needs and wishes because they had a mental health condition or because their ability to communicate was impaired. Many of the people using the service had complex needs which, at times, needed one to one or two to one support from staff who were trained in specific and specialised areas of care delivery. During our inspection it was not evident that support was being provided to the level people needed, to provide both meaningful activities or ensure their safety.

The service had a registered manager. 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 current registered manager is on maternity leave and an interim manager has been recruited. The operations officer was also working alongside the interim manager to ensure improvements were being made.

The provider's action plan had set deadlines for when the improvements would be achieved. We found at this inspection that none of the deadlines had been met.

Although some care plans had been rewritten we still found risk assessments did not always reflect people's identified risks.

Suitable employment checks had not always been made on staff recruited to the service ensuring they were safe to work at Barkby Road. Although staffing levels had improved we continued to have concerns around the deployment of staff. This meant on occasions the most inexperienced staff worked with people with the most complex needs.

Some improvements had been made to the premises and we noted areas had been redecorated and new furniture had been bought. However, the environment in the two bungalows continued to be very poor.

Although people received their medicines as prescribed the temperature of where medicines were stored continued to be of concern as staff were not monitoring it safely and there was still a risk that medicines would exceed the manufactures recommended safe storage limits.

People's personal finances were not always managed safely

People had a choice of food and drink each day and were given these in sufficient quantities. We did identify concerns over food stocks.

Improvements in people being able to access the community were noted however they were not always meaningful and supporting people's aspirations and goals.

Not everyone living at Barkby Road had their dignity supported and maintained.

The operations officer and interim manager had plans to start supervision meetings with all staff but these had not begun when we inspected. Staff continued to feel that they did not receive adequate training and support. They continued to feel unsupported and under-valued by the provider.

Improvements were seen in ensuring people had access to information about the provider's complaints procedure. Information was written in an accessible format suitable for the people using the service.

We continued to find examples of poor management and leadership that impacted on the outcomes for people that used the service. There continued to be a lack of oversight and understanding by the provider about the concerns raised not only by CQC but by the local authorities.

The provider had not ensured there were sufficient processes in place to assess, monitor and improve the quality of the service to maintain the health, safety and welfare of service users. The provider failed to have the systems and processes in place to identify when the service was failing.

At this inspection we found that Barkby Rad were in breach of five regulations relating to safe care and treatment, staffing, governance, premises and equipment. The actions we have taken are reported at the end of the full report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their

registration.

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.

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.

Further information is in the detailed findings below.

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.

The process for determining potential risks to people's safety, health and welfare were not robust and risk assessment did not always reflect people's actual risks.

Accidents and incidents were not analysed and were not considered when reviewing people's assessments and care plans to mitigate risk.

Improvements were needed to the environment.

Recruitment practices were not robust. Staffing deployment did not always reflect people's needs.

People received their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not effective in all areas.

A system to support staff through supervision and appraisal was not in place. Training was insufficient to support staff to carry out their role.

The premises required improvement internally to support people's needs.

DoLS authorisations where appropriate had been applied for. Ongoing improvements in care plans are needed to reflect the condition stated in the DoLS.

People were happy with the meals they received.

People's access to healthcare support was inconsistent.

Is the service caring?

Requires Improvement

The service was not caring in all areas.

People did not have their dignity consistently supported. Delays

in purchasing furniture meant people did not have suitable beds for extended periods.

People were positive about the care they received and were complimentary about the staff.

Positive interactions between people using the service and staff were observed.

Is the service responsive?

Requires Improvement

The service was not responsive in all areas.

People's care plans did not provide a comprehensive record of people's care needs. People's views were not sought or used to develop and review their care plans.

Opportunities for people to engage in meaningful activities were very limited.

Is the service well-led?

Inadequate

The service was not well led.

The staff team felt unsupported by the provider and continued to lack confidence in them and how the service was being run.

The provider had not kept under review the day to day running of the service, to assure themselves that people using the service achieved the best possible outcome in their care and support.

The provider did not have systems in place as to the governance of the service. There were no reliable and effective systems to assure people's views were sought or opportunities given to influence the service they received.

The lack of oversight of the service had resulted in areas of improvement not being identified.

Poor and ineffective record keeping and communication impacted on the quality of the service provided.

External stakeholders had identified improvements were needed.

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 29 October 2018 and was unannounced. We returned on the 30 October announced. Due to further information of concern we returned unannounced on 26 November 2018.

The inspection team consisted of two inspectors and a specialist advisor.

Before our inspection we reviewed all the information we held about the service. This included notifications which contained details of events and incidents which the provider is required to notify us about by law. We also looked at information provided through the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

The commissioners for health and social care, responsible for funding people who used the service had shared information with us concerning the service. This information was used to inform our inspection planning.

We spoke with four people using the service and asked them about their experiences. We also spoke with the operations officer, two interim managers, the deputy manager, four team leaders and five care workers.

We looked at the recruitment records for four staff and staff training information. We looked at a range of documents including meeting minutes, audits and complaints and records relating to how the provider monitored the quality of the service being provided. We also looked in detail at the care records of six people using the service including their medicine records.

Inadequate

Is the service safe?

Our findings

At our last inspection 30 May 2018, we found four breaches of the regulations. Three breaches of Regulation 12, Safe Care and Treatment, Regulation 15, Premises and Equipment, and Regulation 18, Staffing. We rated safe as Requires Improvement; people were not consistently protected from risks relating to their health and safety. People did not have risk assessments that reflected their needs. We found the service to be unclean and poorly maintained and staffing levels were insufficient to keep people safe.

At this inspection we found the provider had made some progress to making required improvements. However, further improvements were still required. We found continued breaches of the Regulations.

Following our last inspection in May 2018, a Leicestershire Fire Officer had visited and issued a 'Deficiencies Notice' requiring improvements. This included ensuring there was a suitable fire exit from the enclosed garden and ensuring structural fire safety precautions were suitably maintained. The provider had complied with these recommendations. Leicester City Health and Safety Officer had also visited in September 2018 and raised concerns over the safety of the premises. We were told by Leicester City Council that the provider had failed to remedy the failures in the health and safety of the building sufficiently to keep people safe. This included remedial building work to be completed and improved security. During our follow up visit on 26 November 2018 we saw that building work was taking place to remedy the failings.

During our visit on 29 October 2018 we were told a serious leak to the roof was to be addressed with scaffolding being used to access the area and assess what remedial work needed to be done. We were told by staff during the inspection this leak was ongoing and had been reported several times over the years. During our inspection we saw obvious signs of water damage to the ceiling and we found a bucket at the top of the stairs collecting rain water. Staff told us that this was routine practice when it rained. Water also regularly came through the ceiling from where water overflows from people's showers. This was a known problem and was raised at the last inspection. It still had not been addressed causing significant concern for people and staff. Following our initial visit on 29 and 30 October 2018 we received information of concern regarding the condition and safety of the building. We were told that when it rained it came through the ceiling and down electrical light fittings placing people at serious risk. We discussed this with the operations officer during our follow up visit on 26 November 2018. They confirmed the maintenance person had identified the issue without the need to access the roof and remedial work would take place to stop the leak. We discussed this with the maintenance person who showed us what the problem was and how it could be rectified.

We were also told by staff during the inspection the heating in one of the bungalows was often ineffective and this meant the bungalow was cold. We noted the condition of this bungalow was also a cause of concern. The furniture was damaged along with the walls and the skirting board missing. The provider's action plan referred to 'sufficient resources' being provided and that work would be completed by 31 October 2018. When we visited 29 and 30 October work had not been completed and in some areas not started.

During our follow up visit on 26 November 2018 there were painters and decorators in evidence in the main building and repairs were taking place. The problems with the heating had been resolved as the operations officer told us the maintenance person had bled the radiators and they were now working more efficiently.

We found the two bungalows were still in very poor decorative and maintenance order and no improvements had been made. We were told the persons who lived in the bungalow had complex needs and they often had behaviours which included damaging their environment. The operations officer was not aware of any plans to improve the environment in the bungalows.

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

People living at the service had complex needs associated with their learning disability and or Autism that affected their mood and behaviour. This resulted in people presenting with behaviours that were a risk to themselves and or others. We found positive behavioural support plans that were used to provide staff with guidance of how to safely and effectively manage people's challenging behaviour, lacked specific and up to date information. Such as how to effectively use diversional strategies to support the person. Staff had received accredited training in the use of physical intervention, but people's behavioural support plans and risk assessment, did not record what type of hold staff should use and what the duration should be. Neither was there any consideration to any other factors such as health needs that could pose a risk to the person or that the least restrictive action should be taken.

Whilst some staff could tell us and demonstrate how they supported people in physical intervention, we received mixed reports of what the duration of a hold could be. One staff member said up to three minutes, whilst another said 1.5 minutes. We also found that the duration of a hold was not consistently recorded on incident forms.

One person's behavioural support plan and risk assessment stated they were at risk of sustaining injuries due to their level of self-harm. During October 2018 incident forms showed the person had sustained a number of injuries that included bruising, swelling to wrist and elbow, a cut to their hand and a fall. Records did not show that staff had sought healthcare advice or support. Records did not show that staff had followed guidance of arranging for the GP to review the person. We discussed this with the operations officer and we strongly advised seeking health care support for this person. Following the inspection visit the deputy manager sent us email confirmation they had sought further healthcare support.

Staff were clear that physical intervention should be used as a last resort. Whilst we saw some diversional strategies were used to manage challenging behaviour this could be improved upon. We saw how a person experienced heightened anxiety during the staff shift handover. Staff told us this was a known trigger to cause distress, however, there were no plans in place to engage the person in a positive activity that would distract them during this time.

We looked at incident forms, ABC charts (antecedents, behaviours and consequences) and records of physical intervention. We found these lacked detailed information and were often incomplete. There were significant omissions including a lack of follow up, in terms of physical injury. For example, bruising which may have developed following an incident. There was a lack of management oversight and sign off, as a result there was often no escalation via monitoring reports, and also a lack of information relating to behaviours in ABC charts. This meant that staff were not given the opportunity to learn and develop improved strategies to manage people's behaviours. During our follow up visit 26 November 2018 we saw a new recording form had been introduced. There was some improvement in analysis but they still lacked

information about who was reviewing the incident and what were the lessons learnt. Staff also told us they still did not receive any debriefing following an incident where restraint had been necessary.

Risks to people's healthcare needs had not always been sufficiently risk assessed. For example, a person who was a diabetic did not have a risk assessment that provided staff with guidance of action required if they became unwell. Staff told us they had not received training in understanding diabetes which they felt they would benefit from.

We had received information from the local authority regarding a person experiencing a reaction to a food they had eaten. We looked at this person's care plan and although it mentioned they were allergic to the food stuff, there was no associated risk assessment that provided staff with guidance if the person ate this food. The plan also mentioned they were allergic to another food but this was not highlighted on the front information sheet to ensure all staff were aware of the allergy nor was there an associated risk assessment. This meant staff did not have the relevant information to ensure the person was kept safe.

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

People living at the service had complex needs and required high staffing levels to meet their individual needs and safety. This was either one or two staff per person. At the inspection in May 2018 we had concerns about the poor staffing levels and the high use of agency staff. During this inspection some staff reported staffing levels had increased in the last three weeks and the use of agency staff declined. New staff were in the process of being recruited. The management team told us they ensured a minimum of 10 staff were on shift during the day and five at night. This could increase to 12 depending on appointments and activities. The staff rota confirmed this.

We did raise our concerns regarding the deployment of staff with the operations officer. For example, staff skill mix was not sufficiently assessed and considered. One person required the support of two staff and on the second day of the inspection they were supported by an agency worker and a new member of staff, employed four weeks with no previous experience in working in care. We were told this person was experiencing frequent episodes of high distress and anxiety levels, resulting in episodes of challenging behaviour that posed a risk to themselves and others. Whilst we were told the agency staff member had worked at the service before, we were not sufficiently assured these staff had the required, skills, knowledge and experience to safely manage this person during this time. We also identified staff were expected to provide one to one support to the same person for the duration of their shift. This was a concern due to the frequency and intensity of behaviours displayed. Neither did we see staff receive any support or de-brief from the management team.

We saw a report refer to an incident between two people living at the service. It stated a member of staff coming on shift witnessed the incident whilst the two people were in the communal lounge by themselves. One person involved should have been on one to one support but no staff were present at the time. We discussed this with the operations officer who told us that staffing levels had improved and incidents such as this should not happen in the future.

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

People told us that staff were available when they needed them. One person commented, "I need two staff to go out with me and I have this." Another person told us, "There's always staff around." Staff comments

included. "Staffing levels were really poor but in the last three weeks with the new management team they've really improved. We're using less agency staff and new staff have been recruited. And "Staffing levels are much better we now have 10 staff on but I think we could do with one or two more so we could do more activities with people as some people need three staff to go out." One member of staff told us, "The agency they have been using are not good. They are a big problem, they don't turn up or when they do they do nothing. The previous agency we used were much better." The operations officer told us they were due to meet with the provider of the agency to discuss these concerns.

Recruitment practices were not robust and did not ensure staff recruited were suitable to work with people living at the service. Records we looked at showed appropriate checks being not carried out, such as obtaining two references and criminal reference checks. We saw evidence that an audit had taken place following our last inspection in May 2018 and identified short falls in the files. However, we saw no evidence of any further action to remedy this. During the second day of our inspection the operations officer made arrangements for each recruitment file to be checked and any gaps identified with an action plan of what needed to be done to bring them up to standard. During our follow up visit on 26 November 2018 the operations officer confirmed DBS checks had been made on all staff who did not have a current one and references had been requested where gaps had been identified. (A DBS check provided information as to whether someone was suitable to work at this service).

At the last inspection in May 2018 we noted that 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.) The provider had told us in their action plan that a fan would be obtained to reduce the temperature. At this inspection we saw a fan was available for staff. However, records showed that the temperature regularly reached or exceeded 25C. We also found that the recording was not consistent, with dates often not running chronologically. There was no risk assessment in place to show what action staff needed to take if the temperature reached or exceeded 25C.

We also noted that where people were given 'as and when' medicines (PRN) these were not recorded on a medication administration record sheet but in the daily notes. It did not record if the medicine had been effective for the person. This meant staff would not have the information to give to healthcare specialists if a person was having their medicines reviewed.

People were receiving their medicines as prescribed. We reviewed records in relation to the administration of people's medicines and found that staff were administering these as required. Only trained staff were administering the medicines at the service. We were told that weekly audits were carried out to ensure there no errors. We saw the last audit was carried out 3 October 2018 and there had been nothing since that date. We were given no explanation why they had not taken place. We spoke with the operations officer who told us they would ensure the audits would be carried out following our inspection. During our follow up inspection on the 26 November 2018 we saw that audits were taking place at weekly intervals.

At our last inspection in May 2018 we found that the service was unclean and untidy. During this inspection we noted some attempt had been made to improve the cleanliness of the service. Cleaning schedules had been introduced on the day of our inspection but it was too early to comment of the effectiveness of these. People were encouraged and supported to complete cleaning tasks and this was observed. During a tour of the service we looked at people's bedrooms and ensuites facilities. We found ensuites to be dirty and in need of a deep clean. During our follow up visit on 26 November 2018 we saw bedrooms were significantly cleaner and people's ensuite facilities were being deep cleaned to remove mould patches. The operations officer told us this was ongoing and cleaning schedules would ensure staff cleaned people's ensuites sufficiently in future to prevent them becoming dirty. Staff spoken with confirmed they had a cleaning

schedule and this was being followed.

Hand wash guidance was on display, and paper towels, liquid soap and hand sanitiser were available for staff to use. We saw staff used gloves and aprons appropriately when supporting people with personal care. During our inspection in May 2018 we found areas such as the conservatory and the dining room had previously been used by staff and maintenance people to discard items they did not know what to do with. We found these areas had been tidied and now were being used by people living at the service. However during our visit on 26 November 2018 we noted that a leaf blower had been left in the conservatory area. This was brought to the operations officer's attention to make arrangements for it to be removed.

Staff were clear about their role and responsibilities to protect people from abuse and avoidable harm. Some staff had used the whistle blowing procedure in the past to report concerns and action had been taken by the previous management team to investigate concerns. A 'whistle-blower' is a staff member who exposes any kind of information or activity that is deemed illegal, unethical, or not correct within an organisation.

People we spoke with told us they felt safe. One person commented, "The fence makes me feel safe, stops people coming in. Sometimes people shout and I get up-set but staff are around." Another person said, "I talk to staff if I'm upset. I feel safe all the time." One member of staff told us, "I feel people are safe living here, some people have complex needs, I worry for (person) we all do because of their level of behaviour."

We checked people's personal finances. We noted that one person had lost their bank card. We spoke with the deputy manager who told us they had checked with the bank and no money had gone from the person's account so they knew it had not been stolen. It appeared that due to poor recording when the card was used they could not ascertain who had had last used it. The deputy manager told us the organisation was currently lending money to the person until a new card can be arranged. The procedure for staff taking people's cards should be two staff sign records. We found this was not always happening. We brought this to the deputy manager's attention who told us they would ensure suitable recording was carried out in future.

Requires Improvement

Is the service effective?

Our findings

At our last inspection carried out on 30 May 2018 we found one breach of the Regulations. Regulation 18, Staffing. We rated the service as requires improvement, staff were not suitably skilled to meet the needs of the people using the service and keep them safe. At this inspection we found the provider had made some of the required improvements. However, further improvements were still needed.

We saw no evidence that the service kept staff updated with best practice guidelines and that people's care was based on best available evidence which would promote a good quality of life. During the follow up visit on 26 November 2018 we discussed this with the operations officer who told us that once all the actions set by the local authority and CQC had been met they would look at addressing these improvements in keeping staff better informed in changes in practice.

Staff felt they would benefit from additional training in managing and understanding people's behaviour. Training continued in the main to be provided online with face to face training for ECCR and first aid. (ECCR is Ethical Care Control and Restraint which uses broad strategies when addressing challenging behaviour uses physical intervention against minor, moderate or extreme aggression). One staff member commented, "When I first started a few years ago, training was excellent and prepared me for the work. I am not sure it is as good for new starters." They added, "When I started I was trained to look at diversion and calm a situation down and the last resort would be 'breakaway'. We would divert by watching the TV that sort of thing. Safe hold and breakaway were always seen as the last option. I feel the newer staff don't always know what to do. A lot has changed in the last few months." During our follow up visit 26 November 2018 we spoke with three new members of staff and a staff member who had worked at the service for some time. We were told that the use of restraint had been reduced significantly. A new team leader told us that they worked alongside staff to support them in managing people's behaviours in a more positive manner. They told us, "We are working with staff to not to use restraint straight away and that it should be the last resort. I think there has been that culture but we are trying to slowly change staff attitudes." A new member of staff told us, "Since I started in September I have rarely seen restraint being used. I have never been involved in it."

Staff responsible for administering medicines told us they had received training and this was initially followed by three observations of practice, but they could not recall having received further medicines observations of practice. Staff told us training covered; communication, learning difficulties, mental health and half a day of autism awareness. A staff member told us, "I don't think this is enough, particularly with how complex people are here." Another staff member said, "No one is checking on performance, there's no monitoring." We discussed this with the operations officer and an interim manager. They told us the plan was to provide support to staff by monitoring practice, discussing it in supervision as well as team meetings. Further training would be offered if staff felt they needed it.

Staff told us supervision meetings were infrequent and no one could recall having had an appraisal. We found no evidence in staff files that supervision or appraisals had been carried out since the last inspection. In discussion with the new deputy manager, the acting manager and the operations officer we were told that supervisions and appraisals would be implemented shortly as a new rota for these has been developed. The

provider's action plan following the inspection May 2018 told us this would be completed by 8 October 2018. During our follow up visit 26 November 2018 we saw the minutes of a recent team meeting where the operations officer introduced the new interim manager. They said they would be starting supervisions shortly so the new interim manager could meet and get to know all the staff team. Staff told us they were aware that supervisions would be starting shortly.

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

People told us they liked the food at Barkby Road. One person commented, "I like the food it's nice. My favourite is sausage and mash. We have fruit, snacks and supper." Another person told us, "We get good food and we go out to places, we go to McDonalds. We're having a coffee morning tomorrow." A staff member told us, "One person is diabetic which is diet controlled, they love their food, we have to be careful and always encourage them to have healthy options. A couple of people eat very quickly, meaning they are at risk of choking, we encourage them to eat slowly and observe them when eating."

We identified concerns around food stocks. Whilst food was delivered during the inspection, stocks had become very low. We had received information of concern from the local authority related to low food stocks. We had been told by the local authority a person had ended up being restrained due to exhibiting behaviours. They had been asking for a cup of coffee during the day but this had not been given as the service had run out of milk and staff had not bought any more. The management team told us changes were being made to how food stocks were checked and food ordered. The food budget had also been increased. During our follow up visit 26 November 2018 there were no concerns around food levels or people having access to food when they wanted it.

Whist there was not a menu on display for people to advise them of the menu choice, this was later found and was displayed. A team leader told us they developed the menu that was based on people's choices and discussed at weekly resident meetings. Healthy eating was promoted, fruit was available and we saw this was offered to people. A staff member said, "We used to use a picture menu for people but we've not done that for a long time now." People had access to the kitchen with the support of staff and were offered menu choices and assisted staff with their drinks and snacks. Throughout the day we heard staff offer people choices of food and drinks. We noted a plate of sandwiches was taken from the main house to one of the bungalows and a food cover was not used. This should be done to minimise any risk of contamination.

Staff shared information with external health organisations in people's ongoing care. For example, NHS grab sheets were used to share information about people's healthcare needs. Records confirmed where concerns had been identified with people's health, they had been supported to attend their GP.

People were supported to access healthcare services. This included dental and optician checks, and chiropody. Records were often not clear as to when people accessed healthcare services and what the outcome was. We discussed this with the operations officer who said they would implement changes to the recording of these appointments. We saw this in place during our follow up visit. People had their medicines reviewed by the GP or psychiatrist and changes were noted in the medicine administration records. Staff had worked with specialist health care professionals such as an occupational therapist and a speech and language therapist. It was not always clear that advice had been followed. We were aware the management team had requested an urgent assessment of a person due to an increase in self-harm behaviour and self-isolation. Following the inspection, this request was confirmed by email from the deputy manager. People were due to be visited by the GP for their annual health check and this had been arranged with the GP. However we did note staff had failed to access health care advice in accordance with a person's care plan,

when they self injured.

Following our last inspection, the provider had told us that improvements to the environment would be completed by 31 October 2018. This included a new low stimulus room and laundry room within the main house. When we visited on 29 and 30 October 2018 this work had not started. Although the deputy manager told us this work was to start soon we were not given a date for when they expected this to start or for completion. We had also been told by the provider in the action plan that the person who needed the low stimulus room was attending a low stimulus environment elsewhere in Leicestershire. Following the inspection the provider sent us photographs of the person visiting a low stimulus environment. During our follow up visit on 26 November 2018 we saw work had started on creating the low stimulus room.

We were told by the local authority that in June 2018 a person whose bed had been broken had been reinforced by using the doors off their wardrobe. During the inspection we were told that they were still waiting for the bed to be replaced. We had email confirmation on 7 November 2018 that the bed had been replaced. This meant the person was without a suitable bed for five months. The local authority also told us another person who, due to their behaviours, had destroyed their mattress, was sleeping on a yoga mat. The provider told us the mattress needed to be purchased from a specialist company and there was a delay of 10 days before it was delivered. This had been replaced when we inspected on 29 October 2018.

A refurbishment plan was in place and some improvements had been made such as redecoration, curtains, pillows and quilts being purchased. More robust furniture was in the process of being purchased to replace damaged and unsuitable furniture. A new ensuite for one person had been fitted. We were told people had been involved in choosing new colour schemes for their rooms and in the purchase of curtains and carpets. We noted throughout the first two days we were present at the service the heating was not warm and asked the maintenance person present to check the heating. We were told by staff that the heating is often ineffective and the home cold. When we visited again 26 November 2018 this had been resolved by the maintenance person.

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. The application procedures for this in care homes and hospitals are 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 were being met. Three people had a DoLS authorisation. All had conditions. Records demonstrated there was some awareness of the to conditions made but it was not always clear staff were consistently following these . During our follow up visit on 26 November 2018 we saw in the care plans we viewed had the conditions reviewed by the management team. In a discussion with the local authority they confirmed people's care plans linked to their conditions better reflected what needed to take place.

Whilst there were some examples of MCA assessments and best interest decisions, they were very limited and were not always reflected in people's care plans. For example, some people had restrictions on the frequency of caffeine based drinks. Staff told us this was because excessive drinks caused people to become unwell. However, people's care records did not show this had been discussed with healthcare professionals and neither was there a mental capacity assessment and best interest decision completed to support this

restriction on people. The operations officer had already identified a review of people's capacity to give consent to their care and support was required and had plans in place to do this. During our follow up visit on 26 November 2018 we saw work had started on improving the mental capacity assessments for people. This would ensure people's capacity to consent was fully assessed and care plans reflect how staff should support people.

Staff were aware of the principles of the MCA and DoLS. This included people being supported as fully as possible in making decisions themselves. Throughout the inspection we saw staff supported and encouraged people in decisions about their care. Choices were offered in relation to meals and drinks and these were respected and acted upon. One person asked to go out in the afternoon and this was respected and the person supported.

The deputy manager told us a new induction had been introduced which included all new staff to meet and greet people living at Barkby Road as well as having four, seven hour shifts to get used to the service where they would be given time to read care plans and spend time with people as well as shad owing more experienced staff. Staff confirmed the induction included reading policies and procedures, support plans, meet and greet with people and shadowing staff. They told us they found this useful.

Requires Improvement

Is the service caring?

Our findings

At our last inspection carried out on 30 May 2018 we found one breach of the Regulations. Regulation 9, Person centred care. We rated the service as requires improvement; people were not treated with respect and compassion due to the levels of staff on shift. People did not receive person centred care.

At this inspection we found the provider had made some of the required improvements. However, further improvements were still needed as there were inconsistencies in staff's approach to people.

One person was in a constant state of undress (including in the garden of the property) we saw no attempt made to ensure this individual was shielded from the view of the public, staff, or other people living at Barkby Road. There was no reference to this in the care plan in terms of what approach should be adopted to maintain this person's dignity. This person's living environment was stark and poorly maintained. Staff were unsure of how this person's needs could be addressed in light of their distress and behaviour.

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

Staff used effective communication and listening skills with people. Some people used sign language and gestures to express themselves and staff easily picked up on what people were expressing. They too used sign language and gestures to aid their communication with people. Staff used different communication approaches with people, indicating they knew them well and understood people's different communication preferences. When people became anxious staff were responsive, they gave people time, listened to them and supported the person effectively.

People told us they liked the staff. One person said, "Staff are friendly, (name of staff member) is my keyworker, they take me out." Another person told us, "I like living here, and get on well with everyone. All the staff are nice and friendly, I get up and have a coffee with the night staff. (Name of manager and deputy) I like them and pleased they are here."

Staff showed a real interest and caring approach towards the people in their care. They showed concern when people became anxious and self-harmed and managed incidents of challenging behaviour in a calm and caring manner. However, where a person was displaying some behaviours that challenge, a staff member was heard to say, 'You won't go out tomorrow if you carry on.' This was inappropriate and punitive. When we discussed this with the member of staff they said they had picked this up from other staff. We discussed this with the operations officer who said they would speak to all staff about how they approached people using the service.

People were involved and consulted daily about their care and support and resident meetings were happening. We saw a meeting taking place during the course of our inspection. The deputy manager told us these were now happening weekly. However, there was no evidence from records that people were involved in the development or review of their care and support plans.

Independence was promoted as fully as possible. People were encouraged to assist staff with cleaning tasks, people were encouraged to assist with their laundry and assisting with making drinks and snacks.

At the last inspection May 2018 we had noted that the sofa in the communal lounge was in a very poor state of repair, this had been replaced and when we returned 26 November we saw that other chairs had been provided. The operations officer told us that a variety of styles of chair or sofa was available as some people preferred chairs and some sofas.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection carried out on 30 May 2018 we found one breach of the Regulations. Regulation 9, Person centred care. We rated the service as requires improvement, people were not receiving care to meet their individual needs and preferences. People were not getting the care and support they required, were not involved in ongoing assessments of their care and support needs and were not supported to live their lives in the way they would choose at the service.

At this inspection we found the provider had made some of the required improvements. However, further improvements were still needed. We found one continued breach of the Regulations.

The provider used an electronic system to record people's support needs and risk assessments. These were found to not provide staff with sufficient guidance and information to support people in a person-centred way. We spoke with new staff who confirmed that electronic support plans lacked information and guidance. Written support plans were being reintroduced and we saw an example of these and found them to be more detailed and informative but still required improvement.

The provider's action plan stated all care plans would be reviewed and rewritten by 8 October 2018. The local authority and health authority clinical commissioning group had raised concerns with us that they continued to find care plans lacking in basic information to ensure people received effective care. We discussed this with the operations officer who told us care plans had been rewritten following the last inspection in May 2018, however much of the key information had been lost when records were transferred to an electronic process. They had now started to rewrite care plans again. During the inspection on 29 and 30 October 2018 we saw this taking place. We looked at one plan that had been rewritten and found it was much improved but still lacked key information regarding how restraint should be used. We brought this to the operations manager's attention who told us they would address it. During our follow up visit 26 November 2018 we saw two more care plans rewritten and found they had improved. This was also confirmed by the local authority during their visit which took place 29 November 2018.

One care plan we looked at did not accurately reflect that person's current care needs. The person was described as very distressed and observed exhibiting high levels of behaviour which were both complex and challenging. This was not sufficiently addressed in the care plan and there was no meaningful joined or single plan which included specialist health and social care support from outside of the service. We could not see a co-ordinated approach from the multi-disciplinary team or evidence that referrals had been expedited.

People received limited opportunities to participate in activities of interest. This had been impacted on by poor staffing levels. A staff member told us one person loved to go out and frequently asked to go to the seaside but this had not happened and their opportunities to access the community was infrequent. Another staff member told us a person was able to go out on the provider's bus with two staff, but needed three staff when in the community. They told us because three staff were not always available, the person had to remain on the bus with a staff member whilst the other staff member went to purchase what they

person wanted from the shop. During our follow up visit on 26 November 2018 we discussed this with the operations officer who told us the person only needed two to one support but staff did not feel comfortable with only two staff. They were in the process of working with staff to improve their confidence and competence when working with this person.

It was not clear from records seen how well the occupational therapist sensory assessment for a person had been understood by the staff team, or whether or not the advice had been consistently implemented.

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

There were no daily activity plans or structure to people's day. There were no plans to support people with dreams, goals or aspirations. The management team told us and people confirmed, there had recently been an increase in activities and weekly meetings had been introduced where activities were discussed and plans made to support people with their activity choices. During our follow up visit on 26 November 2018 the operations officer confirmed once all the care plans were rewritten they would work with staff to develop daily activity plans alongside people living at Barkby Road to ensure they had regular meaningful activities. Following the inspection we spoke with a person from the local authority who told us they saw some evidence this work had started.

During our inspection a person was supported to attend a dental appointment, shopping and café. Another person was supported to visit their relative, three people were supported individually to go out into the local community. On the second day of our inspection, the decorators were painting the lounge. Staff supported people to go to a local town where it was market day. Another person was supported to access the local community. In the evening people were supported to have their evening meal out.

People told us about the activities they had recently participated in which included; a visit to a zoo, they also told us they were looking forward to a Halloween party and bonfire party they were planning. People also told us they had a choice of what time they got up and went to bed.

People told us they would talk to staff if they were upset or had any concerns or complaints. Easy read complaint information was made available. A person told us who the provider was and that the 'head office come out and see us."

No person was at the end of their life, but there were plans to discuss people's end of life wishes with them.

The service looked at ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016. It makes it a legal requirement for all providers of NHS and publicly funded care to ensure people with a disability or sensory loss can access and understand information they are given. At the previous inspection we found information was not always provided in an accessible format. At this inspection we saw the complaints process was displayed in a pictorial form along with other information people would need to know about their service.

Inadequate

Is the service well-led?

Our findings

At our last inspection carried out on 30 May 2018 we found one breach of the Regulations. Regulation 17, Good governance. We rated the service as Inadequate.

There was a severe lack of adequate senior management oversight to ensure the safe running of the service and ensure that people were adequately protected from the risk of harm. The systems and processes in place did not enable people to receive a quality service and resulted in a number of concerns being raised.

At this inspection we found the provider had made limited improvements and further improvements were still needed. We found a continued breach of the Regulation.

The registered manager was on maternity leave at the time of the inspection.
Frequent management changes had led to a deterioration of the service. Staff told us that the frequency in the change of managers had a negative impact on the service, there had been inconsistencies in leadership style with changes to documentation, routines and processes. One staff member told us, "They introduce new documentation and we don't always know about it or how to use it. We have had so many new managers come in and they each have their own style." This had led to a high turnover of staff and a lack of direction. During our follow up visit on 26 November 2018 we met the new interim manager who had started on 19 November 2018. They told us they had previous work experience in this sector and had also been involved in supporting a service to improve where concerns were raised by the local authority and CQC.

A new operations officer had been employed on 10 September 2018 but had initially been told by senior management at Chartwell Care Trust not to be involved with managing the changes at Barkby Road. The operations officer became aware at the start of October 2018 improvements were not being made despite the interim manager giving assurances they were. This showed the senior management team had not been monitoring what improvements were being made until the operations officer made their own checks.

Staff told us they did not feel felt well supported, valued or involved in the development of the service. Staff felt the provider showed a lack of commitment towards the service such as making no attempt to improve the environment until outside agencies insisted on this. Staff we spoke with also spoke of a bullying culture and felt unable to raise concerns with senior management in case they were sacked. We had also received information of concern through the whistle blowing process about how senior management were not supportive and were reluctant to provide the necessary resources to make the improvements.

We found continued shortfalls in the accommodation, which included the maintenance of the building. The lack of regular maintenance had led to the significant problems with water egress around the roof of the main house as well as an extremely poor environment in the two bungalows.

During the first day of our inspection on 29 October 2018, we noted some improvement had been made to the premises. Decorators arrived during our second day of inspection to paint the communal lounge. However, staff were given short notice and had to make alternative arrangements for people living at the

service so they were not present during the work. Risk assessments for visiting trades people were minimal and did not address areas of risk such as preventing people from accessing paints and other hazardous fluids. Staff told us that they often did not know when work people were coming or if they did they sometimes did not arrive. We spoke with the operations officer and they confirmed this had happened on occasions.

The operations officer was introducing new quality assurance systems to ensure problems were identified and improvements were made. However, as the management team were focussing on the required improvements the quality assurance systems had yet to embed and we were unable to comment on their effectiveness.

The operations officer confirmed other agencies had identified shortfalls within the service. There was significant concern with regard to a lack oversight by the provider and senior management team. Action plans imposed by CQC following the last inspection, the local authority and CCG had not been fully met.

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

Staff awareness of the aims and objectives of the provider remained inconsistent. Some staff felt they understood the service was there to provide a good quality of life for people who lived at Barkby Road. Others were less sure. One staff member commented, "I believe we are here to support the guys and give them a good life. I am not sure (provider) thinks the same."

All services registered with the Commission must notify the Commission about certain changes, events and incidents affecting their service or the people who use it. We refer to these as notifications and we found the interim manager had sent appropriate notifications to us.

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 This is a continued breach. The provider failed to provide care that reflected people's needs and supported them to meet thier goals and aspirations. The provider had failed to involve people in developing and planning their care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment This is a continued breach. The premises continued to be poorly maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure staff were deployed with the correct skills and experience. The provider had failed to ensure suitable checks had been carried out on staff employed at the service.