Achieve Together Limited

Berkeley House

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Berkeley House is a residential care home registered to provide accommodation and personal care for up to 19 people who have learning disabilities or autistic spectrum disorder. The service is provided in four separate houses, The Windmill, The Granary, The Bakery and Pippin, and is set in large grounds. There were 8 people living at the service at the time of the inspection. Following the inspection undertaken on 20 October 2021 we took urgent enforcement action to impose conditions on the providers registration for this service. As a result of this action, The Bakery was closed and seven people moved from the service to new homes.

People's experience of using this service and what we found
People were not supported to have maximum choice of control of their lives and staff, management and the provider 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.

People had been unlawfully restrained by staff and had been harmed. There were insufficient staff to meet people's complex needs. Staff did not have the skills or competencies to support people when they were displaying incidents of distress and people's human rights were not upheld.

People's health needs were not met. When people needed support with their health conditions, they did not receive it and this led to people suffering unnecessary harm. People were given medicine they didn't need, and this had an impact on their quality of life.

There was a closed culture in the service which was not person centered. Leadership at the service was inadequate. There was insufficient oversight of the quality and safety of service people received. This led to people being unsafe and harmed.

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

This service was not able to demonstrate how they were meeting the underpinning principles of Right Support, Right Care, Right Culture. We found that care was not person-centered and did not promote people's dignity, privacy and human rights. People were not supported by staff in a dignified manner and restrictive practices were used.

Enforcement
We have identified breaches in relation to staffing, mitigation of risks, medicine administration and management oversight at this inspection. Immediately following our inspection, we wrote to the provider to

inform them of the seriousness of the concerns we had identified. The provider informed us that they were unable to make the necessary urgent improvements and that they would be closing the service. The provider stopped providing a service to people at Berkeley house from 30 October 2021. The service has now closed.

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.

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

Rating at last inspection and update: The last rating for this service was inadequate (published 22 December 2021).

Why we inspected
We undertook this targeted inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in response to concerns received about staffing levels, unlawful restraint being used, unsafe medicine administration and lack of management oversight. A decision was made for us to inspect and examine those risks.

CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At the last inspection this key question was rated as Inadequate. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service well-led?

Inspected but not rated

At the last inspection this key question was rated as inadequate. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Berkeley House

Detailed findings

Background to this inspection

The inspection
This was a targeted inspection to check whether the provider had met the requirements of the specific concern we had about staffing levels, use of restraints, unsafe medicine administration and lack of management oversight.

Inspection team
This inspection was undertaken by two inspectors and one inspection manager.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with one permanent support worker, five agency support workers and three supporting managers from another service. We carried out various observations throughout the inspection visit.

We reviewed a range of records. This included four people's care records daily records and medication records. A variety of records relating to the management of the service, including rosters were reviewed.

After the inspection
We looked at training data sent to us.

Inspected but not rated

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Inadequate. This meant people were not safe and were at risk of avoidable harm. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

Assessing risk, safety monitoring and management; Using medicines safely;
At our last inspection the provider had failed to do all that was reasonably practicable to assess and mitigate risks to people's health and safety. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

● People were at risk of harm because risks to their health, safety and well being were not well managed or mitigated. At the last inspection we identified significant risks to people's safety. At this inspection further serious risks were identified which significantly impacted on people's safety, health and wellbeing.
● People did not receive the care and support they needed to ensure they or others were safe. Known risks to people were not assessed or well managed, and people were left at risk and without support. One person had frequent incidents of distress where they spat, head butted and throat punched people they lived with and staff. Despite these incidents of distress being known and documented, there was no positive behaviour support plan for the person or any clear guidance in place to assist staff supporting them. Records showed that people had been harmed. Staff we spoke with had no knowledge of how to support this person safely or effectively. This placed them and others at ongoing risk of significant harm.
● People had been unlawfully restrained by staff. Staff involved in these restraints did not have any training in physical restraint and there was no agreement in place or best interest meeting to agree this action. No consideration had been given by staff to ensure people's human rights were upheld or that they were safe. Following incidents people's risk assessments and care plans had not been updated. No steps to protect other people were taken. Staff did not have the skills, specialist training or competencies to minimise people's behaviours of distress before they escalated and they failed to protect other people from harm. This had a major impact on the safety of people in distress and the people they lived with.
● When people were at risk of harm because of their health conditions, they did not receive the support they needed to keep them safe or well. One person suffered with chronic constipation. Despite their records showing this, there was no clear care plan in place to support them with this health condition. This put them at risk of significant harm. Staff we spoke with told us they would seek advice from a GP in the event of the person being constipated for two days, this had not happened. Records showed that between 29 September 2021 and 4 October 2021 the person did not have a bowel movement and was chronically constipated. Despite this, staff failed to seek advice, treatment or support from healthcare professionals for them.
● One person had guidance from the Speech and Language Team (SaLT)in place to protect them from the risk of choking. The guidance stated that all food needed to be cut into small pieces. Staff supporting the

person had not been made aware of this guidance and were not following it. One member of staff told us the person could be breathless after food and make throat clearing noises. This indicated signs of choking. No action was taken to reduce the risk of choking, or to seek healthcare advice when concerns around breathlessness and choking were observed by staff. Despite guidance from SaLT, neither the registered manager or provider had ensured there was a risk assessment in place to support this person's safety, nor had they ensured staff were aware of the guidance or the risks of choking for this person. This placed the person at risk of harm.

● Another person had been assessed by SaLT and was at high risk of choking. The assessment stated they needed a soft and moist diet, their food (including bread) cut into small pieces, the position they ate in needed to be considered, and they needed to use a specialised spoon. There was no guidance, care plan or risk assessment in place to ensure this person was supported appropriately or safely with eating. Staff we spoke with were not aware of the SaLT assessment and told us they had given the person food which did not meet the guidance set out by professionals.

● Another person's SaLT assessment showed they must avoid rice as it was difficult for them to process. This guidance was not followed, and we saw records which demonstrated they had been given and had eaten rice. This placed the person at risk of harm. Another person had an intolerance to a number of foods including soya. Despite guidance being in place for this, records showed they had been given soya to eat, and this resulted in them suffering an incident of distress.

● People's medicines were not managed safely. One person had 'as required' (PRN) medicines prescribed to support them to manage their behaviours of distress. The guidance for this medicine states that it should only be administered when they were agitated or aggressive. Records showed, and staff confirmed that they were administered this medicine twice daily, and the administration of the medicine was not linked to any incidents of distress. The person had been receiving sedative medicine everyday whether they need it or not. This complete failure to adhere to medical guidance regarding this PRN medicine placed the person at risk of ongoing harm of receiving treatment they did not need, and which has a major impact on their daily life.

● The provider failed ensure safe and appropriate medication administration and failed to ensure staff were competent in following clear instructions on medication administration records and in this person's PRN medication guidance.

The failure to take appropriate actions to mitigate risks to people's health and welfare, and the failure to administer medicines safely is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014

Staffing and recruitment

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

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● Since the last inspection a number of staff had left the service. At this inspection there were insufficient staff to ensure people's needs were met. This had a major impact on people's safety.

● People were being supported by staff who did not understand their needs or how to support them. Most of the staff providing support to people were temporary agency staff. They had not received an induction, or read people's care and support plans, or received training.

● Agency staff spoken with said, "I only started working here about 3 to 4 months ago. We are asked to support anyone. I do not know the person I am supporting. I have never read their care plans."

● Since our last inspection a new management team was in place at the service. They told us they were not able to supervise, observe or guide staff, or undertake any competency assessments to ensure staff caring for people had the right skills and knowledge to provide appropriate support. They told us they did not know the staff and could not be sure they were providing safe care.
● People had complex health and support needs. These were not known by staff and people did not receive safe or appropriate support. Some people required 1-1 support, and this was not consistently provided. This led to incidents of distress escalating, and these incidents were compounded by the fact staff did not know people or how to support them. The provider told us they could not keep people safe and were unable to ensure there were sufficient staff with the right skills and competencies to support people.
● We did not look at staff recruitment on this targeted inspection. However, on previous inspections no concerns had been identified in this area.

The failure to provide sufficient numbers of suitably qualified, competent, skilled and experienced persons is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014

Inspected but not rated

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. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about. At our last inspection the provider had failed to ensure that people were treated with dignity and respect. They had also failed to ensure that people were supported to consent to their care and treatment. This was a breach of regulations 10 (dignity and respect) and 11 (need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection the provider also failed to ensure there was effective governance of the service and to fulfil their role in relation to duty of candour. This was a breach of regulation 17 (good governance) and regulation 20 (duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
At the last inspection the provider also failed to notify the Commission of significant events. This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Following the last inspection we took urgent enforcement action in respect of the above failings.

At this inspection we found the provider was still in breach regulations 11, 17 and 20. We did not specifically assess any improvements against any other regulation as this inspection was targeted to look at specific areas of serious concern in relation to the management of risk and the leadership and governance of the service.

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

- There was a lack of effective leadership and oversight of the service which left people at risk of harm.
- There were several managers on site during our inspection. However, they did not know people well and were on site dealing only with administrative matters.
- Staff were not supported by management and our observation showed staff were overwhelmed. In one unit there were five agency staff and only one permanent member of staff. This permanent member of staff provided direct support to one person who needed 2:1, administered three person's medicines and cooked for all three people in that unit. They were also left to oversee the agency staff. Agency staff told us that they did not know how to meet people's needs and required direction from the senior staff, but that they were unable to get this direction as there was only the one senior staff. We have described under the safe section of this report incidents of unsafe responses to people's needs. These had arisen from staff not knowing how to support people. The registered provider entrusted the care of vulnerable service users to staff who had provided unsafe care and people had suffered harm and were at significant risk of ongoing harm as a result.
- Staff told us they had not been listened to. For example they told us that they had raised with managers the need to monitor the bowel movements of a person at risk of severe constipation but that "The

management did nothing."
● We saw that staff, who were supporting people on a 1-1 basis to keep them safe, were not provided with relief cover when they took a break. This placed both people and staff at risk of harm as people had periods of time when they did not receive the staff support they needed.
● The provider had not identified the issues we found with staffing, medicine misuse, risk management or care planning. The governance systems had been ineffective in identifying the shortfalls. Failings identified at the previous inspection a week earlier had not been addressed.
● Records were not adequately maintained. For example, we found loose sheets of paper stapled to people's daily records, which contained significant information. It stated, 'Awake all night. appeared very unsettled throughout the night. He has been banging his head against the wall, clapping and making series of noise. He just became settled at 07:05am.' We found no further action taken or referral to a healthcare professional. This meant people's care needs might not be evaluated and met due to poor record keeping.

The failure to operate effective systems and processes to assess, monitor and improve the quality and safety of the service and failure to ensure records were accurate, complete and consistent was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered provider and registered manager had not ensured that legislation and guidance had been followed when planning or providing care. For example, people's Deprivation of Liberty Safeguards (DoLS) had expired. While some were in the process of being renewed, one person's DoLS expired 10 May 2019 and had not been renewed. People were being restraint without their consent or the proper legal authorisation. The provider had not acted within the law to protect people's rights and their liberty.

This was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 registered provider did not fulfil their responsibilities in respect of the duty of candour. The provider had not always been open and honest with people and their families about things that had gone wrong in the service. They had not always informed external agencies of any incidents or accidents.
● Immediately following this inspection the registered provider informed us that they were unable to make the necessary improvements to the service and that the service would be closing the following day. The service closed on 29 October 2021 and everyone was required to move out at short notice.
● Whilst the provider was honest with people's relatives about no longer being able to meet their needs at Berkeley House people's relatives told us that the provider had not given people reasonable notice of the closure of the service. They raised concerns about the manner in which people were treated on the day they were required to move. We also received information from health care professionals that told us that on the day people were required to move the provider's representatives and senior leaders did not treat people and their families with consideration and empathy.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.