IBC Quality Solutions Limited

Tarry Hill

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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Tarry Hill is a residential care home providing accommodation and personal care to 17 people at the time of the inspection. The service is registered to support up to 26 older people and younger adults with a learning disability or autistic spectrum disorder.

The service is set out over five mews style houses behind a locked gate. The service had been developed before the principles and values that underpin Registering the Right Support were published. This is guidance that aims to ensure people using a service can live as full life as possible and achieve the best possible outcomes that include choice, control and independence.

Tarry Hill is larger than current best practice guidelines dictate and is a campus style setting with five houses in close proximity and staff regularly coming and going between each house to complete tasks. The outcomes for people did not fully reflect the values and principles of Registering the Right Support because they lacked independence.

People's experience of using this service and what we found
Information about risks to people's safety were not always up to date or clear. Management plans did not always meet current national guidance around the prevention and control of infection in relation to Covid-19. The provider did not always follow relevant national guidance around the administration and recording of medicines. When things had gone wrong, reviews were conducted but did not always identify areas for improvement. The provider had not always spoken with all relevant external professionals regarding people's care needs.

The registered provider had not taken responsibility for ensuring staff were suitably trained. The physical environment was not adapted to a consistent standard to meet people's needs. The systems and processes the provider used to assess the safety and quality of the care people received were not effective.

Peoples relatives, staff and external professionals all told us the registered manager had been a positive influence on the service and the culture had improved in time she had been employed. Since the last inspection the registered manager had implemented improvements and restraint, seclusion and segregation were now only used as a last resort. The registered manager adhered to improvement plans suggested by safeguarding professionals.

Some improvements had been implemented since the last inspection, however, some were yet to be fully embedded and further improvements were still required.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported

this practice. People exercised choice over their food and drink options and were supported to eat and drink what they wanted.

Rating at last inspection (and update)
The last rating for this service was Inadequate (published December 2019) and the service was placed in special measures. At this inspection enough improvement had not been made or sustained and the provider was still in breach of some regulations, however the rating had improved and therefore the service was no longer in special measures.

Why we inspected
This was a planned focused inspection to follow up on breaches in the previous inspection report. This report only covers findings in the Safe, Effective and Well-led key questions. 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 changed from Inadequate to Requires Improvement. This is based on the findings at this inspection.

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

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

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

Follow up
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 alongside the provider and 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.

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

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 well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Tarry Hill

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.

Inspection team
This inspection was carried out by two inspectors, an assistant inspector, a specialist learning disability nurse advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Tarry Hill 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, including notifications and reports the provider had sent to us. 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.

During the inspection
We spoke with five people who used the service and nine relatives about their experience of the care provided. We spoke with 16 members of staff including the registered manager and area manager. We reviewed a range of records. This included six people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with eight external professionals who are connected to the service.

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 Inadequate. At this inspection this key question has now improved to Requires Improvement. 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.

At the last inspection we found the provider was failing to deliver safe care and treatment. 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.

Assessing risk, safety monitoring and management

- Information about risks to people's safety were not always up to date or clear. For example, risk assessments around night time medicine administration did not explore the risk of people not receiving their medicines in a timely manner.
- Risk management plans for the spread of Covid-19 did not provide staff with clear, up to date guidance about this.
- Where people had refused to be tested for Covid-19, management plans were not always in place to enable staff to quickly recognise signs of the virus. Where management plans were in place, they were not always followed consistently.
- There had been improvements in risk management since the registered manager was appointed but some staff told us they still felt some people's safety was at risk. One staff member said, "There's not a proactive approach to risk, I've raised that two people were approaching a crisis and no-one listened to me, there was no follow up." We saw the person they referred to was experiencing increased anxiety and plans were not in place to prevent this happening even though staff knew the reason and had made suggestions about how to prevent this.
- The risks of people sharing a house with a person they didn't get along with were not explored. At the last inspection we identified a person became anxious because they didn't like or understand another person's behaviours. At this inspection we saw this was still the case, one person had repeatedly expressed they did not like living with another person, they had started to take their meals outside to ensure they took these alone. The registered provider had not addressed this.

Preventing and controlling infection

- The registered provider did not ensure all staff met current national guidance around the prevention and control of infection in relation to Covid-19. We saw not all staff wore appropriate personal protective equipment (PPE) such as surgical masks.
- Staff we spoke with did not have a clear understanding of how to detect and prevent a potential spread of

Covid-19. One staff member said, "There's no PPE, hardly any staff wear masks, when [Name] came home from hospital they weren't shielded as they're supposed to be." Another staff member said, "Staff wear PPE in the house I work in, I had to insist on this." One staff member showed us a box of surgical face masks with a note on that guided staff to only use one face mask per shift. This created a risk that staff could be wearing contaminated PPE and against government guidelines for Covid-19 in care homes.
● The registered provider had not arranged a designated area for staff to put on and remove PPE at the beginning and end of their shift, as stated in government guidelines. Staff did this in communal areas. This meant people around the home were not protected from the potential spread of Covid-19.

Using medicines safely
● The registered provider did not always follow relevant national guidance around the administration and recording of medicines. The procedures left people at risk of not always receiving their PRN (as required) medicines in a timely manner.
● There was not always medicine trained staff on night shifts, this meant an on-call senior staff member would be called to support the staff on duty. Staff on duty had not received training or been assessed as competent to recognise when someone might require their PRN medicines, such as pain relief, relief of a high temperature, asthma or to calm anxiety.
● Where people had taken PRN medicines, staff were not prompted to document the reason for this. This is against national guidance and meant there was a risk of people displaying symptoms that weren't reviewed by senior staff or a healthcare professional.
● There was not always a record of people's medicines as required by national guidance. One person was prescribed a PRN medicine for in case they experienced a seizure, this was not recorded on their Medicine Administration Record (MAR). We saw this medicine had been hand written on previous MARs dating back to January 2020. Guidelines state that care home providers should only hand write medicines on MARS in exceptional circumstances, such as an emergency prescription for antibiotics.
● Some staff we spoke with told they refused to be responsible for administering people's medicines because they didn't feel confident they were managed safely and wanted to avoid being blamed for making mistakes.

Learning lessons when things go wrong
● When things had gone wrong, reviews were conducted but did not always identify areas for improvement. For example, derogatory language was routinely used by staff when recording people's behaviours. The registered manager had reviewed the incidents but did not identify this concern. Two external professionals told us they had previously raised this with the registered manager and registered provider.

Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Throughout the inspection the homes appeared clean and were free from malodours.
● Some improvements had been implemented in medicine management since the last inspection, the registered manager had introduced a new procedure they had assessed as more suitable and this was with a view to reducing the number of medicine errors.
● Investigations into accidents and incidents had been improved since the registered manager was appointed, however we identified further improvements were still required.

At the last inspection we found the provider had failed to ensure there were enough suitably trained staff on

duty to keep people safe. 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. (The reason for the continued breach of Regulation 18 is explored in the Effective section of this report).

Staffing and recruitment

● We found there were now enough staff on duty to meet people's needs, however, staff and relatives told us there was a high staff turnover and people were not always supported by someone they knew or felt comfortable with. One relative said, "There are a lot of agency staff and a lot of staff change, this upsets [Name]." A different relative said, "[Name] became anxious due to the high turnover of staff." One staff member said, "Turnover of staff is huge here, in one house especially, so much agency and they don't know people like we do."

● We discussed staffing with the registered manager and external professionals, both told us that there had been a high turnover of staff whilst the registered manager was driving forward improvements and they employed the same regular agency staff to cover vacancies as much as possible. Recruitment was on-going.

● The provider operated safe recruitment practices. Staff were subject to pre-employment checks including background checks and references.

At the last inspection we found the provider had failed to protect people from abuse. This was a breach of Regulation 13 (safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

Systems and processes to safeguard people from the risk of abuse

● Since the last inspection the registered manager had implemented improvements and restraint, seclusion and segregation were now only used as a last resort. However, a few weeks after the inspection we were informed of staff using a physical restraint on one person, this was referred to the safeguarding team and investigated by the police.

● Although, generally relatives and staff felt they were able to identify and report concerns, some relatives felt they were not always listened to. One relative told us they were frightened of speaking with us and raising concerns because they felt this could lead to their relation receiving unkind treatment. Some staff told us they felt their concerns about people's care and weren't always taken seriously.

● The registered manager engaged with the local authority safeguarding professionals and adhered to improvement plans they suggested. However, there were instances where the communication with people's own social workers was not clear.

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 Inadequate. At this inspection this key question has now improved to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

At the last inspection we found the provider had failed to ensure there were enough suitably trained staff on duty to keep people safe. 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.

Staff support: induction, training, skills and experience

- The registered provider did not ensure the learning, training and development needs of staff were carried out at the start of employment, or that staff were appropriately supervised until they had successfully completed their mandatory training. This meant people were at risk because they could be supported by staff who were not trained to keep them safe from harm.
- Where people had complex communication needs the registered provider had not ensured staff completed appropriate training to meet these. Only eight of the staff at Tarry Hill had completed training in communication.
- Staff completed the majority of their training in their own time, the registered provider failed to recognise it was their responsibility to ensure people were cared for by staff who were suitably trained to meet their individual needs.
- Training staff had completed was not always effective. We saw repeated incidences of staff referring to people using derogatory words such as, 'abusive' and 'intimidating'. This showed staff did not know how to understand people's behaviours or respect their dignity and human rights.
- The majority of the training staff completed was on-line and did not assess their competency in that area. The registered manager did implement spot checks on staff but had failed to recognise the lack of staff understanding around people's behaviours.

The provider had failed to ensure staff received appropriate training to enable them to carry out the duties they were employed to perform. This was a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 the last inspection we found the provider had failed to act in accordance with the Mental Capacity Act. This was a breach of Regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvement had been made at this inspection and the provider was no longer in breach of Regulation 11.

● Practices around the way the provider assessed and reviewed people's ability to make their own decisions had improved since the last inspection. People were involved in their own decision making processes and were helped to make informed choices by being given information in a format they understood. However, this was not always done consistently, and further improvement was still required. Some of the records we reviewed were not up to date and some included errors. We discussed this with the registered manager who told us this was a work in progress and records were still being updated.
● Where people were deprived of their liberty this was in line with the conditions set out in their DoLS and the least restrictive option was used. We saw staff interact with people and help them to make decisions in their best interest.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

At the last inspection we found the provider had failed to fully assess people's needs and provide person-centred care. This was a breach of Regulation 9 (Person-Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were not able to judge if the breach of Regulation 9 had been met. This was mainly explored in the Caring section of the last inspection report. Due to The Covid-19 global pandemic we were only conducting focused inspections and therefore only the Safe, Effective and Well-led sections were reviewed during this inspection.

● At this inspection we saw people's individual positive behaviour support plans had been updated and these now included guidance for staff about people's behaviours and how to recognise what may trigger people to become unhappy. Staff knew which de-escalation techniques to use to help reduce people's anxiety.
● We spoke with external professionals who told us they had been consulted about people's positive behaviour support and their advice was adhered to. However, we found some areas where national guidelines were still not followed. For example, general principles of care were not always followed because

staff had not always been supported to understand people's communication needs.
● One person told us they felt increasingly unhappy because they couldn't go on holiday, staff told us they anticipated this because the holiday was an annual event. The person's preferred holiday destination was open this summer but the provider had not explored the possibility of this person being able to go on holiday. They had not adopted a proactive approach to making sure plans were in place to achieve the happiest outcome for this person. External professionals had not been contacted to discuss the possibility of planning a holiday in this person's best interest.
● The registered manager worked with the local authority and multi-disciplinary teams to review people's care. However, they had not sought clinical advice when implementing new medicines procedures and therefore had not been supported to identify where national guidelines were not being followed.

Adapting service, design, decoration to meet people's needs
● The physical environment was not adapted to a consistent standard to meet people's needs. Tarry Hill is a campus style congregate setting, there are five houses and an external courtyard behind a locked gate. This is against best practice guidance detailed in Registering the Right Support. This was identified at the last inspection and the registered provider had not implemented changes.
● We saw staff came and went between the five houses without knocking on the doors or seeking the consent from the household to enter. This made the service feel more like a campus and created an institutionalised and less homely feel.
● There were not always quiet areas for people to spend time alone other than their bedroom, the external courtyard was a busy and noisy environment. Some communal areas were lacking personalisation and home comforts. Further improvements were required to adapt the service to improve people's quality of life and promote their well-being.
● People and their relatives were involved in the design and decoration of their bedrooms.

Supporting people to eat and drink enough to maintain a balanced diet
● People exercised choice over their food and drink options and were supported to eat and drink what they wanted. Staff ensured there was food and drink available that was stored and prepared in a way that met people's cultural beliefs.

Requires Improvement

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 now improved to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

At the last inspection we found the provider had failed to ensure the safety and quality of the service. This was a breach in Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17.

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

- The systems and processes the registered provider used to assess the safety and quality of the care people received were not effective. Although improvements had been made since the last inspection, further improvements were required. The registered provider and registered manager had not identified the concerns we found with medicines, lack of staff training or the environment.
- The registered provider had not taken responsibility for ensuring staff were suitably trained. Staff did not get paid for the majority of their training and were expected to complete this in their own time. Where staff had not completed training, the registered manager had reminded staff but had not prevented them from working unsupervised where required.
- There was a lack of consistent guidance and information for staff to follow to understand how many staff should be present with people to ensure people received the staffing hours they were commissioned for.
- Documents relating to people's care were written inconsistently. Some were adhering to best practice guidance, others were not. We reviewed some documents that were not signed or dated, and some referred to the wrong person. This showed the registered provider had not retained oversight of records relating to people's care.
- There was no deputy manager in post. There had been four different people who had been appointed to this post in eight months. The lack of deputy manager meant the registered manager was at times over stretched trying to identify areas for improvement, design, implement and drive forward improvements whilst managing a staff team.

The provider had failed to assess, monitor and mitigate risks to the safety of people using the service. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care

● The registered manager had instilled a strong emphasis on service improvement. Many improvements had been made since the last inspection and the registered manager informed us this was still a work in progress.

● However, the area manager had reviewed the service shortly before the inspection and had failed to recognise the significance of some of the areas where improvements were yet to be embedded to ensure they could offer improvements to people's quality of life.

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

● People's relatives told us the registered manager had been a positive influence on the service and the culture had improved in time she had been employed. However, we did receive mixed feedback about the potential for people to achieve good outcomes. One relative said, "Managers don't bother, and staff are not respectful, I can't complain because I am worried about the way they might treat [Name]." A different relative said, "The new manager is very professional and is approachable."

● All staff we spoke with spoke positively about the registered manager, though some told us they had raised concerns about people and these concerns were not acted upon. One staff member said, "I can go to the registered manager, I know she'd listen, but this company is about making money, we don't do enough to make sure people have nice lives, not everyone here does have a nice life."

● External professionals spoke highly of the registered manager, though some told us they feared the workload taken on by the registered manager was unsustainable due to a lack of effective support from the registered provider.

● The registered provider's strategy for supporting improvements at Tarry Hill, was at times unrealistic. People living there had complex needs and we did not see a credible long term strategy that focused on ensuring people led full and active lives.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The culture of the service was not always transparent, we received mixed feedback about this. Some relatives told us they feared punitive measures against their relation if they raised concerns. However, some relatives spoke highly of open and clear two-way communication between themselves and the service.

● Some staff told us they felt they had been banned from speaking honestly with us. Some staff contacted us after the inspection to share positive feedback, though a number of these did so anonymously which meant we were unable to use their feedback as part of this inspection.

Working in partnership with others

● The service engaged with external professionals and multi-disciplinary teams. However, we received feedback from some professionals that the registered provider relied heavily on their guidance and did not always demonstrate an understanding of nationally recognised guidelines or best practice guidance. Three different external professionals told us there was a lack of effective communication as they hadn't been informed of certain incidents.

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

At the last inspection we found the provider had failed to act in an open and honest way with key people. This was a breach in Regulation 20 (Duty of Candour) of the Health and Social Care Act 2008 (Regulated Activities) 2014. The provider had also failed to notify us of certain incidents. This was a breach of Regulation

18 (Notification of Other Incidents) of the Care Quality Commission (Registration) Regulations 2009.

Enough improvement had been made and the provider was no longer in breach of these Regulations.

● The provider had informed all relevant people when a person had an accident or had become unwell, this included people's relatives.
● Providers are legally required to notify us when certain incidents occur, we reviewed the notifications we had received since the last inspection against the accident and incident records and found we had been notified accordingly.
● Providers are required to display their most recent CQC ratings on their website and within the service. We saw both had been done.

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 12 HSCA RA Regulations 2014 Safe care and treatment Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and mitigate risks to the safety of people using the service.

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 received appropriate training to enable them to carry out the duties they were employed to perform.