Easy Living Care Limited

Barnhaven Residential Care Home

Inspection report

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22 July 2016

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Ratings

Overall rating for this service	Inspected but not rated

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

Summary of findings

Overall summary

Barnhaven was registered with the Care Quality Commission on 4 February 2016. We have not yet carried out a comprehensive inspection and therefore the service does not have an overall quality rating.

We received a concern which related to poor care practice at the service. This included how medicines were managed and how decisions had been made for two people, which impacted on their privacy and dignity. As a result we undertook an unannounced focused inspection on 22 July 2016. This report only covers our findings in relation to the concern.

We judged improvements were needed in the management of medicines, how consent is sought from people and how their capacity to consent is assessed. One area of concern identified did not respect the dignity of two people and did not respect the privacy of a third person. During the inspection, we also found two areas of concern in relation to the quality of pre-admission assessments and care plans. There were not effective systems to monitor the quality of care and support that people received.

During this inspection we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to medicines, safe care and treatment, seeking consent, person centred care, dignity and respect and good governance. You can see what action we told the provider to take at the back of the full version of the report. We contacted commissioners at the local authority about our concerns on the same day of the inspection.

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

Two aspects of the service were not safe.

People's medicines were not always managed in a safe way. Some medication was not managed in a safe manner.

Some risks to people's health were not regularly reviewed. Therefore people were potentially at risk of their health deteriorating.

Is the service effective?

Requires Improvement

One aspect of the service was not effective.

Decisions had been made on behalf of people without ensuring they had the capacity to agree to them and without ensuring the decision was in their best interest.

Is the service caring?

Requires Improvement

One aspect of the service was not caring.

Staff did not always ensure people's privacy was taken into account in shared bedrooms. People's privacy was not always maintained.

Is the service responsive?

Requires Improvement

One aspect of the service was not responsive.

Assessments and care plans did not reflect people's individual needs. Some records had not been fully completed which could potentially impact on the quality of people's care.

Is the service well-led?

Requires Improvement

One aspect of the service was not well led.

Effective systems were not in place to continually monitor and improve the quality of care and support people received.

Barnhaven Residential Care Home

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 checked whether the provider is meeting the legal requirements and regulation associated with medicines, consent and planning for people's care under the Health and Social Care Act 2008.

We undertook a focused unannounced inspection in response to a concern raised about the quality of the care. We inspected the service against all of the five questions we ask about the services: is the service safe, is the service effective, is the service caring, is the service responsive and is the service well-led? This report only covers our findings in relation to the concerns.

We visited Barnhaven on 22 July 2016. The inspection was unannounced and was carried out by one adult social care inspector.

We reviewed information about the service before the inspection. This included contacts about the home and notifications sent to us. A notification is information about important events which the service is required to tell us about by law.

We met with six people and spoke with three out of the six people about their experiences of care at the home but two people were unable to comment specifically on their care. We spoke with the provider and the registered manager. We reviewed records relating to medication practice and looked at care records for three people, a cleaning schedule for the kitchen, minutes from a staff meeting and communication sheets for staff.

Requires Improvement

Is the service safe?

Our findings

A concern had been reported to us about the way some medicines were managed in the home. During this inspection we looked at the arrangements for the storing and the recording of medicines which needed additional security.

We found that some areas of medicines management needed to be improved.

Staff used a register to record the use of medicines which needed additional security. There were entries which showed only one staff member had signed to say the medicines had been administered; this was not safe practice. The registered manager said they had met with staff administering medicines to highlight this was not the correct practice; there was no record of this meeting. We checked the stock of medicines needing additional security against medicine records. There were inaccuracies, which had not been identified by the registered manager. We also saw one person's medicine had not been returned to the pharmacist, although the person had died. The registered manager arranged for this to happen during the inspection.

Some medicines needed to be kept in a medicine's fridge; we checked how the temperature of the fridge was monitored. We saw on 15 out of 26 days there was no record of the temperature being checked by staff. The registered manager said the temperature should have been checked on a daily basis.

Some people were not protected against risks to their health and action had not been taken to prevent the potential risk of harm. Records relating to risks to people's health were not meaningful and did not monitor the risk of people being dehydrated. We checked the records for two people who lived at the service permanently and for a third person who was on a respite stay only. This was to see how risks to their health were managed. For example, a person was unwell and a health professional visited the person. The health professional advised the person should be encouraged to drink more fluids. A daily fluid chart had been started but there was no record of how much the person should be encouraged to drink. Some fluid records were undated, some had few entries and daily amounts of fluids were not totalled which meant there was the potential for the person to become dehydrated. Other records relating to the person's catheter did not provide information to make them meaningful, such as when staff should be concerned and contact health professionals for advice.

Staff had recorded that a person's skin was becoming 'red' and the person had stated their skin felt sore. Records showed this was not being monitored on a daily basis by care staff. Steps were not taken to provide equipment to reduce the risks to their skin, such as a pressure relieving cushion and health professionals were not consulted.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager showed us the records for a person who had been assessed by health professionals

as having difficulty swallowing medicines. The person's care records showed health professionals had confirmed a medicine could be crushed to enable them to swallow the medicine and reduce the risk of them choking.

Requires Improvement

Is the service effective?

Our findings

A concern had been reported to us about the way a decision had been made to move a person to a different bedroom. During this inspection, we looked to see how this decision had been made, if people's consent had been sought and if their best interests had been considered.

Some people's rights were not protected because the registered manager had not acted in accordance with the Mental Capacity Act 2005. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who lack the mental capacity to do so for themselves. The MCA 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.

Decisions had been made on behalf of people without ensuring they had the capacity to agree to them and without ensuring the decision was in their best interest. We checked the care records for two people whose sleeping arrangements had changed. There had been no assessment of their capacity to be involved in decisions relating to their care and their capacity to be involved in a change to their accommodation.

The registered manager said they had spoken to both people about changes to their accommodation. However, no records had been completed to record this discussion. We met both people; neither was able to comment directly on the changes to their sleeping arrangements. In their care records there were several entries that recorded they were distressed by the presence of another person in their room. We were told a relative and social care professional had been approached about the changes of accommodation for one person but this was not recorded. Relatives and social care professionals had not been consulted on behalf of a second person, who had moved rooms.

The registered manager told us they were acting in the best interests of one of the people who had been unsettled at night due to a change of personal circumstances. However, there was no recorded explanation about how the second best person would benefit from the change in their sleeping arrangements, apart from us being told they were a friend of the person. We informed the commissioning body that was involved in the funding for both of the people. They plan to carry out a review.

Two out of three people's care plans had not been signed. Therefore the registered manager could not demonstrate how people had been involved in their care plan and their consent gained. One care plan had been signed by a person's relative but there was no record of their legal powers to represent the person.

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

During the inspection, the registered manager said practice would change relating to consent, which they confirmed in writing. Since the inspection, we have received confirmation from commissioners that each person had returned to their original sleeping arrangements; this meant they were no longer sharing.

Requires Improvement

Is the service caring?

Our findings

A concern had been reported to us about the way a decision had been made to move a person to a different bedroom. We visited a room shared by two people; there was no suitable screening available to ensure their privacy and dignity was respected. For example, when they received support with personal care. Care records showed one person needed regular support with their continence. This showed the decision for them to share did not maintain either person's privacy or dignity.

On one occasion, care records showed one person needed intimate personal care from a health care professional. Staff considered the impact on the person sharing the room and consulted with the registered manager. They agreed for this care to be provided in a room occupied by a different person who at that time was in the lounge. This decision did not respect the privacy of the person whose room was used for intimate care for another person.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

A concern had been reported to us about the way a decision had been made to move a person to a different bedroom. We checked the care records for two people sharing a room, and for a person who was on a respite stay to see how risks to their health were managed.

Improvement was needed to ensure assessments and care plans reflected people's individual needs. For example, one person said they had visited the home before they came for a respite stay, but did not remember being asked about their care needs. Records linked to this visit, which had been completed, contained minimal information. The registered manager said care workers had asked about the person's individual preferences, but these were not recorded.

There was no care plan to guide staff how the person should be supported during their stay. The person told us they did not feel their need for mobility aids had been taken into account, which meant they were struggling to get out of bed without assistance. They told us they had specialist equipment at home which enabled them to be independent when they got out of bed. The registered manager said their assessment had taken place six weeks before their stay and that the person's needs may have increased in this time.

We checked two other people's care plans; one contained some personalised information and the other had blank sheets and was incomplete. The person had lived at the home for over a month.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider and the registered manager told us they were developing care plans as they had recognised this was an area of improvement. They showed us a care plan which had been completed in more detail and was personalised and said they were going to introduce this approach for all the people living at the home.

Requires Improvement

Is the service well-led?

Our findings

We discussed our concerns with the registered manager and the provider relating to the decisions to move people into a shared room without appropriate consultation or planning, and the management of respite stays. For example, a person had been booked for a respite stay but there was not a bed available for them. A person was moved out of their existing bedroom to share a room. The provider said they had not been consulted about the changes because they were on holiday. Since our inspection, the registered manager has provided assurances about how this type of situation will not occur again.

The provider did not have effective systems in place to monitor the quality of care and support that people received. The provider said they were in regular contact with the registered manager and visited the home but had not formally recorded how they had checked on the quality of care at the service.

During our inspection, we saw records relating to medicines and people's care were poorly completed. Audits had not been completed on the quality of records relating to care assessments, care planning, reviews, fluid checks, turning charts and kitchen cleaning schedules, some of which were not dated and incomplete.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered manager had arranged a staff meeting before our inspection after concerns had been highlighted following the quality of documentation after a person's local authority review. The minutes showed she had reminded staff the importance of completing records accurately and with detail. After our inspection, the registered manager told us they had met with care staff regarding record keeping and with the provider to make to improvements to the management of the home.

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 Pre-admission assessments and care plans were not always completed and did not always contain personalised information.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Staff did not always ensure people's privacy was taken into account in shared bedrooms. People's privacy was not always maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Decisions had been made on behalf of people without ensuring they had the capacity to agree to them and without ensuring the decision was in their best interest.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's medicines were not always managed in a safe way. Some medication was not managed in a safe manner. Some risks to people's health were not regularly reviewed. Therefore people were potentially at risk of their health deteriorating.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems were not in place to continually monitor and improve the quality of care and support people received.