MOP Healthcare Limited

Barrowhill Hall

Inspection report

Barrow Hill
Rocester
Uttoxeter
Staffordshire
ST14 5BX

Tel: 01889591006

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Barrowhill Hall is a residential care home providing personal and nursing care to up to 74 people. The service provides support to Older people and those living with dementia, mental health concerns, sensory impairments and younger adults. At the time of our inspection there were 66 people using the service.

People's experience of using this service and what we found
The governance and auditing systems had not identified issues with the quality of the service which meant actions had not been taken to ensure people received good quality care.

Relatives told us communication with the home was difficult and it was hard to speak with the registered manager when they needed to.

People were not consistently supported to manage risks to their safety. Some risks had not been assessed and planned for, and where updates were needed to management plans these had not been documented to guide staff.

Medicines administration records were not consistently completed in line with the policy. Incidents were not consistently reported for investigation and review and reports from staff sometimes lacked detail. Infection prevention control measures were in place and these were followed by staff.

People were supported by enough staff. Staff understood how to recognise abuse and how to report concerns.

Incidents and accidents were reviewed to enable action to prevent this from happening again. The registered manager ensured where things had gone wrong relatives were informed.

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.

Staff felt supported by the registered manager and provider in their role. Relative told us they were asked for their views and these were acted upon.

For more information, please read the detailed findings section of this report. If you are reading this as a separate summary, the full report can be found on the Care Quality Commission (CQC) website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement 5 November 2021.

At our last inspection we found breaches of the regulations in relation to safe administration of medicines. The provider completed an action plan after the last inspection to tell us what they would do and by when to improve.

At this inspection, we found the provider remained in breach of regulations. This is the fifth consecutive inspection where a good rating has not been achieved.

Why we inspected
We received concerns in relation to people's nursing care needs and leadership. As a result, we undertook a focused inspection to review the key questions of Safe and well-led only.
For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.
The overall rating for the service has not changed following this inspection.
We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

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

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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 monitor the service and will take further action if needed.

We have found breaches in relation to how risks to people's safety are managed and the governance arrangements in the home at this inspection.

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 from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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 well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Barrowhill Hall

Detailed findings

Background to this 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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by three inspectors 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
Barrowhill Hall is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and we looked at both during this inspection.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.
Inspection activity started on 21 June 2022 and ended on 23 June 2022. We visited the location on 21 and 22 June 2022.

What we did before the inspection

We reviewed the information shared with us by other agencies and the information we held from notifications and concerns raised by the public. We used the information the provider sent us in the provider information return. This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.

We used all of this information to plan our inspection.

During the inspection
We spoke with four people and 12 relatives. We observed the care people received to help us understand the experiences of people who could not talk with us. We spoke to 14 staff which included the registered manager, nurses, senior care assistants and care assistants. We looked at six care records in detail and reviewed aspects of a number of others. We reviewed medicine administration records, training records, policies, incident records, staff files and other records relating to the management of the home.

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 our last inspection we rated this key question requires improvement. The rating for this key question has remained 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 our last inspection we found the provider had not got systems in place to manage medicines safely. This was a breach of Regulation 12 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; Using medicines safely

- Risks were not consistently assessed, and plans put in place to mitigate them. For example, where people had risks related to periods of emotional distress , diabetes and epilepsy management these had been identified as part of their needs assessment but the risks had not been considered and there was no guidance for staff on how to mitigate the risks. This meant people were left at risk of harm.
- Incidents were not always reported by staff. One incident where a person was exposed to potential restraint had not been reported and investigated. This meant the person was exposed to the risk of harm.
- Medicines administration records (MAR) were not always completed. We found MAR charts with signatures which had been missed and we could not be assured people had received their medicines. This meant people's health may be at risk. The clinical lead confirmed these would be reviewed and actions taken.
- Where people required medicines administration to be recorded on a body map to ensure rotation of the site of administration this had not been recorded effectively. This meant people were at risk of harm.
- Care plans had not been consistently updated. For example, where people had changes to the risks with their skin integrity and where people had displayed periods of emotional distress. This meant people were exposed to continuing risk of harm.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Relatives told us peoples medicines were reviewed regularly with input from health professionals. One relative told us, "The staff give [person's name] tablets that are prescribed and the takes them easily."
- Staff sought consent and ensured people were supported to take prescribed medicines.
- Medicines were stored safely and there were stock controls in place to ensure people had enough medicine.

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 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.

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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● People had their capacity assessed and where required decisions were taken in their best interests and recorded.
● We saw DoLS applications were made appropriately and staff were aware when a DoLS had been approved.

Systems and processes to safeguard people from the risk from abuse
● Relatives told us people were safely cared for by the staff. One relative told us, "Since the day [person's name] went in we have been very happy. There are never any doubts about their safety."
● Staff had received training in safeguarding and how to report incidents, however this was not consistently done by all staff.
● The registered manager reported incidents to the appropriate body.

Staffing and recruitment
● Relatives told us there were enough staff to support people. One relative told us, "I visit regularly at weekends and there seem to be enough staff around."
● Relatives told us there were agency staff in use. One relative told us, "We generally see the same people although there are a lot of agency staff which is to be expected. Even the agency staff are good though. They are all kind and treat [person's name] as an individual."
● Staff told us there was enough staff to meet people's needs. We saw people had the care they needed without any delays. The registered manager confirmed there were tools in place to ensure there were the correct number of staff to meet people's needs.
● Staff were recruited safely. We saw the provider carried out checks as part of their recruitment process. This included the disclosure and Barring Service (DBS). DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection including the cleanliness of premises
● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● The home had a system in place to facilitate visiting for people. Relatives told us they were able to visit their loved ones, and this was done safely.

Learning lessons when things go wrong
● There was a monitoring system in place which reviewed incidents and accidents to look for trends.
● We looked at the learning from incidents and found where incidents had been reported the registered manager had a system in place and these had been reviewed and actions to keep people.

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 our last inspection we rated this key question requires improvement. The rating for this key question has remained 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements, Continuous learning and improving care

- The providers system to ensure incidents of possible abuse were reported to the local safeguarding had failed to identify an incident of potential restraint. This meant the person was left at risk of harm.
- Systems were not effectively ensuring peoples risks were assessed and plans were put in place to mitigate risks. This meant people were left at risk of continued harm.
- The provider had failed to ensure medicines administration records were effectively completed. This meant we could not be assured people had received their medicine as prescribed.
- Systems had failed to ensure evaluations of care plans identified changes in need and consideration of incidents had taken place. We saw the evaluations undertaken monthly of peoples care plans and risks had not taken account of times when people had been emotionally distressed. This meant people were placed at risk of harm.
- The provider systems had failed to ensure staff recorded the care people received in their daily care records.

The quality monitoring systems in place were not identifying concerns and driving improvement in the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people, Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People did not always have their health needs met in a timely manner. Relatives told us people had waited long periods of time for visits from dentists and opticians. We found limited reference to visits to the dentist and opticians. This meant people were at risk of their health deteriorating.
- Relatives told us they did not feel the home communicated with them effectively. One relative told us, "They are not very good at communicating. Emails are not answered, and we have to do all the chasing."
- Relatives told us they were not able to easily speak with the registered manager. One relative told us, "The registered manager is not really accessible. You have to make an appointment." Another relative said, "More often than not the registered manager is in their office or in a meeting."
- Relatives told us they were able to make suggestions about improving the service. One relative told us, "I

received a questionnaire. I suggested a change and they implemented it. They have also restarted the family monthly meetings which are in the evening at 6.00 p.m."
● Staff told us they felt supported by the registered manager and others in the management team.

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; Working in partnership with others

● The provider understood the duty of candour. The registered manager could describe how they shared information when things went wrong.
● Relatives confirmed they were always informed of incidents. One relative told us, "[Person's name] has had some falls out of bed. They did call me when it happened. They were not hurt and now has a low hospital bed."
● The registered manager could give examples of how they had worked in partnership with other agencies to implement changes following feedback on the quality of the service. For example, changes to checks and audits which helped with governance had been implemented and were effective in ensuring people received the care they needed.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks were not managed effectively, medicines administration was not consistently recorded in line with the policy and incidents were not always reported.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The governance arrangements in the home were failing to identify areas for improvement and ensure actions were taken to manage risks to peoples safety.

The enforcement action we took:

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