

Barrels UK Care Ltd

The Firs Residential Care Home

Inspection report

Tower Farm
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06 August 2020

07 August 2020

17 August 2020

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15 September 2020

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

The Firs Residential Care Home is a care home that was providing accommodation and personal care to 21 people at the time of the inspection. The service can support up to 29 people.

The Firs Residential Care Home accommodates people in one adapted building. There are shared lounges, a dining room and a conservatory on the ground floor. Bedrooms are single occupancy and are both on the ground and first floors.

People's experience of using this service and what we found

Peoples medicines were not always managed safely which increased the risk to people. Some staff did not always follow current national guidance on when to wear personal protective equipment when supporting people.

People had risk assessments and care plans in place to give guidance to staff on how to monitor people's assessed risks. However, some of these records lacked information to guide staff fully.

Audits had made some improvements to the service provided but had not identified the shortfalls found during this inspection. Staff had been trained on how to keep people safe from poor care and harm. However, there were delays in staff taking action and seeking advice when people had missed their medication. These delays had also not been identified in the governance monitoring of the service.

Relatives of people who lived at the service told us that communication was good, and they felt listened to and involved in their family members care decisions.

There were enough staff to meet people's care and support needs. Staff involved and worked with external professionals to help people maintain their health and well-being. Recruitment procedures were in place to check whether a proposed new staff member was suitable to work at the service.

The registered manager made sure appropriate people and organisations such as the local authority safeguarding team, were informed when things went wrong. They gave people and their relatives opportunities to feedback and make suggestions on the running of the service.

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 requires improvement (published 17 October 2019) and there was one breach of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve (November 2019). At this inspection enough improvement had not been sustained and the provider was still in breach of regulations.

The service remains rated requires improvement. This service has been rated requires improvement for the last inspection (17 October 2019) and rated inadequate prior to that (published 25 May 2019).

Why we inspected

We undertook this focused inspection to check they had followed their action plan and to confirm that they had met the legal requirements. This report only covers our findings in relation to the key questions safe and well-led which contain those requirements.

The inspection was also prompted in part due to concerns received about staffing levels during the COVID-19 pandemic. A decision was made for us to carry out this focused inspection and examine those risks.

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 remained the same. 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 The Firs Residential Care Home on our website at www.cqc.org.uk.

We have found evidence that the provider needs to make improvements. Please see the safe section of this full report. You can see what action we have asked the provider to take at the end of this full report.

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 have identified breaches in relation to the safe management of medicines, infection prevention and control and governance at this inspection. This puts people at an increased risk of harm.

Please see the action we have told the provider to take at the end of this report.

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 set up a meeting with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

The Firs Residential Care Home

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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted as part of our thematic review of infection control and prevention in care homes.

Inspection team

Two inspectors and a pharmacist specialist carried out this inspection.

Service and service type

The Firs Residential Care Home 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

We gave a short period of notice of the inspection. This supported the service and us to manage any potential risks associated with COVID-19.

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 local authority safeguarding team. 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 two people who used the service and five relatives (by telephone) about their experience of the care provided. We spoke with six members of staff including the registered manager, deputy manager, team leader, two house keepers and the maintenance person. We used observations to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included six people's care plans and risk assessments relating to specific risk and health conditions and multiple medication records. We looked at the staff training matrix and a variety of records relating to the management of the service, including policies and procedures.

After the inspection

We continued to seek clarification from the registered manager to validate evidence found. We also spoke with a professional by telephone who visits the service.

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 requires improvement. At this inspection this key question has remained the same. 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.

Using medicines safely

At our last inspection the provider had failed to ensure medicines were managed safely. This was because medicines records were not always appropriately maintained, and records indicated that people had not always received their medicines as directed by a prescriber. 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.

- MARs (Medication Administration Records) were in place for all people at the service to support staff with the administration of medicines, however we found on some occasions there were duplicate records in place. Handwritten MARs had not always been signed and checked. The procedure for how to handle MARs was not covered in the providers medicine policy.
- There was confusing information with regards to allergies and in some cases the allergy information had not been completed on people's MARs.
- Some of the equipment used to administer medicines had not been cleaned. We found a tablet crusher in the trolley with yellow tablet residue. It is important the tablet crushers are cleaned between every administration to avoid cross contamination. We were told there was only one crusher in use for all the people.
- The fridge had been documented as being out of temperature range since 10 July 2020, with no action being taken to rectify the problem.
- One rescue medicine (a medicine that may be needed quickly) was out of date (expired December 2019) in the fridge.
- Protocols to help staff know when to give 'as required' medicines were not always in place. Some were being updated by the registered manager during our inspection.
- On two occasions somebody had missed their regular medicine in the last week, this medicine helped to manage their mental wellbeing. On one occasion a regular medicine had been missed. On another occasion an 'as required' dose had been given. The time of administration was not recorded, and the daily record did not give any details about why this was administered. The running balance of the medicine did not correlate with what had been documented as being administered. This was not in line with the instructions in the person's care plan to document any behaviours to inform the mental health crisis team.
- For one person who may have needed glucose administering in an emergency there was no 'as required' protocol to guide staff as and when this would be appropriate. Four members of staff had been assessed as competent to check blood glucose should the need arise. The diabetes plan did not mention the

administration of glucose in this form.

- The provider allowed people to self-administer their own medicines if appropriate and had a policy to support this. We looked at one person's record who was self-administering. The care plan and risk assessment did not include information for the safe keeping of these medicines, how further supplies would be handled, how monitoring would take place and how these medicines were to be disposed. The current hand-written MAR record contained incorrect dosing information. This was not in line with the provider's policy on self-administration.
- One person who required a medicine for a specific disease was not given the medicine on 21 occasions since 6 July 2020 because they were sleeping. We did not see any evidence in the care plan of what staff were to do in this situation.

Preventing and controlling infection

- Social distancing within the service was not happening as people were often seated together. A staff member did not remove their Personal Protective Equipment (PPE) in line with their training. Also, we saw that not all personal protective equipment was worn when a staff member supported a person with their meal who was coughing. This is not in line with current guidance.
- Cleaning schedule records had not been updated since start of COVID-19 and did not provide prompts around the frequency of cleaning of high touch areas. Not all staff when asked could confirm they had been given advice about the changes to their cleaning schedule since COVID-19. This included the importance of increased cleaning of high touch areas. Our observations showed that staff were not seen regularly cleaning frequently touched areas.
- The COVID-19 infection control policy was last reviewed on 11 March 2020 and contained guidance that was no longer up to date with government guidance.

This is a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Improvements had been made since the provider had been using a different pharmacy. Staff told us the new pharmacy were responsive at addressing issues that were raised with them.
- Processes were in place for the timely ordering and supply of medicines and medicines administration records (MARs).
- We were assured that the provider was admitting people safely to the service.
- The local clinical commissioning group (CCG) delivered Infection Prevention Control training to all staff after a COVID-19 outbreak at the service.

Assessing risk, safety monitoring and management

- Relatives of people who used the service told us they were involved in helping set up and review their family members care plans and risk assessments. A professional said, "[Registered manager] is good at making us aware if somebody needs to be reassessed and will say 'I think [named person] needs to be reassessed by a social worker'."
- Risk assessments were in situ to guide staff and help staff monitor people's assessed risks. However, we found there was a lack of guidance for staff within one person's risk assessment on what to do if they missed their medication due to being asleep. For another person there were inconsistencies in the number of times a day an external health professional supported them.
- This meant we found for some people the risk assessment and/or care plan records did not contain all the up to date information needed to guide staff.

Systems and processes to safeguard people from the risk of abuse

- The registered manager acted promptly during this inspection and on evidence found by the inspection team raised a safeguarding. This was about a medication incident involving an agency staff member.
- Staff told us about their safeguarding training and refresher training. They confirmed their understanding of protecting people from poor care or harm and said they would report any safeguarding concerns. They were also aware of where the safeguarding policy was held should they need to refer to it.
- A staff member talked about a person who displayed distressed behaviours at times. They told us how they supported the person to reduce their anxieties. They said, "We can redirect them by talking about [their interests]." A person told us, "I could talk to any of the staff if I was not happy about something."
- During the pandemic lockdown, the registered manager and staff made sure that people had contact with their relatives and friends as per their human rights. A relative confirmed, "I phone everyday... There is always information to hand when I ring staff... It is important for me to check every day. The (registered) manager went above and beyond because during lockdown my family member has been really quite poorly."

Staffing and recruitment

- There were enough staff on duty during this inspection to support people with their care and support needs. A dependency tool based on people's care and support needs determined how many staff needed to work each shift. Most relatives spoken with were assured that staff had time to sit and speak with their family member due to the feedback they then received.
- The registered manager confirmed that safety checks were carried out on staff to try to make sure they were suitable to work with the people they supported.

Learning lessons when things go wrong

- The registered manager told us that lessons had been learnt during the pandemic about the number of staff at the service that became unwell and/or had to self-isolate. They said they were recruiting to increase the number of staff trained and available to work should there be a second pandemic spike and cover staff shortfalls.

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 requires improvement. At this inspection this key question has remained the same. 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- Audits were undertaken to check the quality of the service provided. Any shortfalls were recorded on an action plan. These audits had led to some improvements but had not identified the shortfalls in safe medicines management or infection prevention and control found during this inspection.
- Action was taken by staff for the person who had missed their medicine on 21 occasions after this had been identified during this inspection. This meant that the governance systems in place were not identifying quickly enough actions staff needed to take.

This is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Relatives spoke positively of the registered manager and staff team. One relative said, "The staff have kept me in touch with [family member] by phone... I have always been quite happy with the way things are for [family member]."
- Staff told us that the registered manager was approachable and would respond to any suggestions or concerns raised. Meetings happened where staff could make suggestions. A staff member said, "[You] can always go into the office and speak to [registered manager]."
- The registered manager notified the CQC of incidents and events they were legally obliged to notify the CQC about.

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;

- Relatives told us they felt staff had informed them of what was happening at the service particularly during the pandemic lock down. A relative said, "Right early on they gave us information about staff testing positive for COVID-19." Another relative told us, "I previously had concerns about the service and contacted the CQC, but I am happy with the service as it is now. I think it has done an admirable job since it had COVID."
- A professional said the registered manager was open about things that had happened at the service and took action to make improvements. They said, "[Registered manager] is open about, this happened, and this did not happen... [Registered Manager] is good at reacting to what you have asked them to do. For example, we asked them to set up video calls for a person. [The registered manager] takes ideas on and works on it."

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

- Relatives meetings were on hold during the pandemic lock down. However, relatives told us that prior to lockdown they could attend relatives' meetings. One relative also confirmed to us they had been asked to complete a survey to give their views on the service being provided.
- Relatives told us they spoke with the registered manager and staff team daily if they needed to, when unable to visit their family member and communication was good. A relative said, "I am reassured by the level of communication we have. I have confidence that if there were any issues, [staff] would contact me."

Working in partnership with others

- Records showed, relatives told us and a professional confirmed the registered manager and staff team worked in partnership with a range of external professionals and agencies. A professional said, "[The registered manager] works well with me."

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 Medicines were not always managed safely. Regulation 12 (1) (2) (g). Guidance was not being followed by staff around safe infection control practices. Regulation 12 (1) (2) (h)