

# Affectionate Healthcare Limited

# Barons Down Nursing Home

## Inspection report

Brighton Road  
Lewes  
East Sussex  
BN7 1ED

Date of inspection visit:  
13 July 2020

Date of publication:  
17 August 2020

## Ratings

Overall rating for this service

Inspected but not rated

Is the service safe?

**Inspected but not rated**

Is the service well-led?

**Inspected but not rated**

# Summary of findings

## Overall summary

Barons Down Nursing Home is a care home with nursing and accommodates up to 30 people in a purpose built building. The service supports adults whose primary needs are nursing care although some are living with dementia. At the time of our inspection there were 23 people living at the service.

We undertook this targeted inspection to follow up on specific concerns, which we had received about the service. The concerns were about people's safety, medicines, infection control and the governance framework of the service. We inspected using our targeted methodology developed during the Covid19 pandemic to examine those specific risks and to ensure people were safe.

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

Risk of harm to people was not always mitigated as serious incidents and accidents were not consistently reported, recorded or investigated to prevent further harm occurring. Action plans to prevent further incidents were not always in place. However since the acquisition of the home on 25th March 2020, action plans had been put into place by senior management to improve oversight. These were shared with CQC on the day of the inspection.

The recording of wound management was inconsistent and did not follow best practice guidance. Staff had not all received an induction and the training they needed to support them in their role. Not all staff had received supervisions and appraisals. Robust systems for the checking of medicine changes were not in place and had resulted in a serious medicine error. However, action in regard to this has been taken to prevent further possible errors.

There was a lack of robust management oversight in some areas of the service. Quality assurance systems did not always identify shortfalls in the service and the provider had not ensured there was a systematic approach to manage improvements. Risks to people's safety were not always monitored, which meant there was a risk they would not receive the safe care they required.

Areas of the home and some equipment was not clean. Recent changes to the number of domestic staff had impacted on the cleanliness of the premises. The nominated individual has taken immediate action to address this issue.

Medicines were stored and disposed of safely. People's medication records were completed, signature gaps had been highlighted and followed up by the deputy manager.

People told us they felt safe living at Barons Down. One person said, "I do like living here, it's safe and the food is good." Another person said, "Very nice place to live, the staff are very good."

Rating at last inspection:

This service was registered on the 27/03/2020 and this is the first inspection.

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

#### Enforcement:

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

#### Follow up

We will continue to monitor information we receive about the service until we return to visit as per our reinspection 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?**

We have not rated this key question as we have only looked at the areas we had specific concerns about.

Details are in our safe findings below

**Inspected but not rated**

### **Is the service well-led?**

We have not rated this key question as we have only looked at the areas we had specific concerns about.

Details are in our safe findings below

**Inspected but not rated**

# Barons Down Nursing 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. This was a targeted inspection due to concerns we had about people's safety and care needs being met and the governance framework to support people and staff safely.

#### Inspection team

The inspection team consisted of two inspectors.

#### Service and service type

Barons Down Nursing 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.

#### Notice of inspection

We gave a short period notice of the inspection. This was because of the COVID-19 pandemic. We wanted to check if anyone was displaying any symptoms of the virus and to be aware of the provider's infection control procedures.

#### What we did before the inspection

Before the inspection we reviewed the information we held about the service and the service provider. We sought feedback from the local authority and healthcare professionals that are involved with the service. We looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law. We used all of this information to plan our inspection.

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.

Due to the COVID-19 pandemic we needed to limit the time we spent at the home. This was to reduce the risk of transmitting any infection. Therefore, we had two calls with the nominated individual for the provider organisation. We discussed how we would safely manage the inspection. We also wanted to clarify the providers infection control procedures to make sure we worked in line with their guidance.

To minimise the time in the service, we asked the provider to send some records for us to review prior to the inspection. This included records relating to the management of the service, audits, training and supervision records and staffing rotas.

During the inspection

We spoke with three people who used the service. We spoke with six members of staff including the nominated individual. We spent a short time in the home. This allowed us to safely look at areas of the home and to meet people and staff whilst observing social distancing guidelines. It also gave us an opportunity to observe staff interactions with people. We spoke with one relative during the inspection.

We reviewed a range of records. This included people's care records, medicine records, four staff files in relation to recruitment and further records relating to the quality assurance of the service, including accident and incident records.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We received feedback from one relative and contacted two more relatives for their comments about the service.

# Is the service safe?

## Our findings

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

We have not rated this key question, as we have only looked at the part of the key question we had specific concerns about.

The purpose of this inspection was to check on specific concerns about people's safety and care needs being met. We will assess all of the key question at the next comprehensive inspection of the service.

Systems and processes to safeguard people from the risk of abuse:

- People using the service were not always protected from harm. We were shown a safeguarding investigation which had involved injury to a person on four separate occasions over a six-month period, before an investigation began. Opportunities had been missed to report and investigate the first three incidents. When the registered manager was asked for documentation relating to the incidents, they admitted that some documentation was missing.
- Issues had been raised alleging serious assault by a carer towards residents. These matters had not been referred to the CQC and had not been thoroughly investigated. A serious medication error occurred which was known to the registered manager but had not been reported or investigated. In all cases opportunities for learning lessons from these incidents had been missed.
- An accident had been recorded where a resident had slipped from their chair on two occasions and been found by staff on the floor. Although no obvious injury had been found the resident had been returned to their chair and no follow up investigation had taken place to prevent it from happening again.
- We spoke to staff about safety. Staff told us that there had been no training provided during the pandemic but they were confident in identifying and reporting safeguarding issues to managers.
- Staff were aware of the service whistleblowing policy. Whistleblowing allows employees to raise issues of concern whilst protecting their anonymity. Staff expressed concerns that the registered manager had not adhered to the policy and that known concerns had been talked about openly.
- There is currently a safeguarding investigation following a serious medicine error. This was an error that initiated from the pharmacy. However, it was not picked up by the registered nurses or staff for 48 hours and a person received a significant overdose. The nominated individual had conducted an internal investigation into the error and a plan for improvements had been made.
- The investigation had identified a lack of competency checks and training in medicine management when changes to the medicine ordering system had occurred. The changes to the person's medicine, due to their swallowing problems had not been recorded within their care plan. Going forward the provider is transferring to an electronic system of medicine management, which will allow more robust checks on medicine ordering, receipt and administration.

From the information gathered, the above evidence shows that the risk of harm to people had not always been mitigated as incidents and accidents were not consistently reported, recorded and investigated. Action plans to prevent further incidents were not in place. This meant that people were not always protected from risk of harm and is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities)

## Regulations 2014.

### Using medicines safely:

- The inspection found that medicines were stored and disposed of safely. People's medication records confirmed they received their medicines as required. Medicines remained stored securely in the clinical room.
- We asked people if they had any concerns regarding their medicines. One person said, "I have no worries, I get my medicines." A second person told us, "The staff are very good with my pills, I get them on time."
- There were protocols for 'as required' (PRN) medicines such as pain relief medicines, which included recording the effectiveness of the medicine.

### Preventing and controlling infection:

- The cleaning of the premises was an area that had been identified by staff that needed to improve. One staff member said, "It's not right that the cleaning team has been reduced to just one, it's not clean enough and she does a good job." Another staff said, "It's not clean anymore, too much to do for one staff member."
- There had been a recent change to the number of the domestic staff. This meant there was only one domestic staff to clean three floors of the home. The result of this meant that the upper floors were not attended to until later in the day and the cleaning was not as thorough.
- There were some odours noted throughout the building, some carpets were stained and bed bumpers were unclean. We noted that the audit for the cleaning of bed bumpers had not been completed since May 2020. This was taken forward immediately by the nominated individual.
- There is an improvement plan with projected timeframes for improvements. This will be regularly reviewed.
- We were sent the Covid 19 infection procedures and policies prior to the inspection. These reflected current guidance and we were told it was updated regularly. All staff were aware of the government guidance and confirmed that they received updates daily. Staff were all wearing protective personal equipment (PPE).
- Staff told us of the infection control policy and of the systems they used in the service to keep people safe during the pandemic. They thought a review of the changing facilities for staff would be helpful.
- It was discussed with the nominated individual that a refresher re the wearing of masks would be beneficial for the staff, including the agency staff.

# 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.

We have not rated this key question, as we have only looked at the part of the key question we had specific concerns about.

The purpose of this inspection was to check on specific concerns we had about people's safety and care needs being met and the governance framework of the service to support people and staff.

We will assess all of the key question at the next comprehensive inspection of the service.

Understanding quality performance, risks and regulatory requirements:

- For this targeted inspection we specifically looked at the management of safeguarding and risk management. We identified failure to act on risk in respect of managing alleged abuse and putting safeguards in place to prevent harm. For example, an incident of abuse occurred which had been reported by staff to the management team. However, no immediate action was taken. The staff involved were not removed immediately from their duties and it was not reported to either the Local Authority or to CQC.
- This incident occurred just before the sale of the care home to the new provider. The current provider has taken action regarding this to ensure that staff are aware of their responsibilities to protect people from potential harm.
- Accidents and incidents were not followed up with no action plan to prevent a re-occurrence. We found repeated injuries were not investigated or cross referenced into the care plan to prevent further injuries. The cause of unexplained bruising had not been investigated. This was despite staff reporting to management when they found bruising/scratches and people reporting that some staff were sometimes rough when moving them and incidences of spiteful teasing.
- Staff told us that they had been shouted at and that this had put them off from reporting internally and so they had contacted the Local Authority and CQC. CQC have received concerns about unexplained bruising which were referred to the provider to investigate.
- Whilst investigating an alleged assault, older large bruising was found on a person, which had not been recorded or investigated. When staff were approached about the bruise, they told us they had presumed it had been caused by sudden deflation of the pressure mattress. However, this was not recorded within care notes.
- Wound care records were lacking in detail of description of injury and treatment. Photographs of wounds were not all dated, named or clear what part of the body was injured. None of the photographs seen for one person were attached to the relevant wound care/accident record. The National Institute for Health and Care Excellence best practice guidance for wound care was not being followed.
- Staff had not received training in wound care management or received competency checks in wound management
- Staff were not supported to perform their role. Not all staff working in the home had had an induction, supervision or appraisal. For example, one staff member employed over a year ago, had not had an

induction, had received no training for their role, supervisions and no appraisal. They told us, they felt "Unsupported, unimportant and of no value."

- There was a high use of agency staff, supplied by a recruitment agency. Agency staff had not received an induction and there were no robust checks taken to ensure their training was valid, such as sight of certificates. Other checks to ensure they were suitable to work in care were not questioned.
- Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The registered manager has not always informed the CQC of significant events including significant incidents and safeguarding concerns.

The nominated individual had recently identified some of the shortfalls we found. An action plan has been provided and we will follow this up at the next comprehensive inspection.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong:

- The feedback from staff about the management of the service was mixed. However, the majority of staff, spoke of a poor and closed culture. One staff member said, "There is a noticeable bad atmosphere in the office, I avoid going there (the office) if I can." Another said, "I have raised some issues, but I wasn't listened to, none of us were, so we had to whistleblow." Another member of staff said, "We have not been listened to, but hopefully the new provider will, they seem to."
- There had been some serious allegations and medicine errors over the past six months. There had been a lack of awareness shown that improvements were needed to safeguard people from re-occurrence. Following an alleged abuse allegation, there was no follow up to ensure the person had not suffered any mental trauma or acknowledgement that something had occurred.

The above examples, demonstrate that the provider's governance framework was not consistently robust. The provider had failed to access, monitor and mitigate the risks relating to the health, safety and welfare of service users and to maintain accurate, complete and contemporaneous records which is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

- We received some positive feedback from people, staff and families. One staff member said, "Really good support from the manager," and "I think it's a well-run home." A family member said, "Overall, I think the care is good."

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment  The provider had failed to ensure that there were systems and processes established and operated effectively to prevent abuse of service users. Regulation 13 (1) (2) (3) HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance  The provider had failed to access, monitor and mitigate the risks relating to the health, safety and welfare of service users and to maintain accurate, complete and contemporaneous records. Regulation 17 (1) (2) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) 2014.