MOP Healthcare Limited

Barrowhill Hall

Inspection report

Barrow Hill
Rocester
Uttoxeter
Staffordshire
ST14 5BX

Tel: 01889591006

Date of inspection visit:
20 August 2018
21 August 2018
28 August 2018

Date of publication:
30 November 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 20, 21 and 28 August 2018 and was unannounced.

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. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Care and support is provided over two buildings, Barrowhill Hall and Churnet Lodge. Barrowhill Hall is spilt into smaller 'units' with Dove House located upstairs. The service is registered to provide care support for up to 74 people. At the start of this inspection 66 people were using the service.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection in December 2017, the home was rated as Requires Improvement overall. At this inspection, we found that improvements had not been made and the home was rated 'Inadequate' and is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

There were not enough staff deployed effectively to keep people safe or to meet their needs. We told the provider about our concerns and they increased staffing levels but we still found that staffing impacted on the safety and quality of care people received, including their mealtime experience.

Risks to people's safety, health and wellbeing were not always suitably assessed, monitored and managed. There was a lack of clinical oversight and the systems in place did not support safe risk management.

We found that medicines were not managed safely and people were at risk of not receiving their medicines as directed by the prescriber.

The registered manager and provider had not operated effective governance systems to ensure that the safety and quality of the service were adequately monitored and improvements made when required. Some people did not know who the registered manager was and not all staff felt supported and involved.

Staff knew how to recognise and report abuse but the systems in place meant the provider could not be confident that people were kept safe from potential abuse and avoidable harm. People's nutritional risks were not managed and mitigated though people told us they enjoyed the food on offer.

Staff teams did not always work effectively together. For example, handovers were not consistent and agency staff did not know the people they were supporting, their needs, risks or preferences.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. However, decisions made in peoples' best interests were not always appropriately recorded.

People told us that staff treated them with kindness and compassion. However, people were not always offered the reassurances they needed because staff did not have time to spend with them. People's dignity was not always respected and promoted, though they had access to privacy when they wanted it.

People were supported to consider their wishes for end of life care and the service were working with a local hospice to help improve this area of care.

People were protected from the spread of infection and the design and adaptation of the service met their needs. The provider had plans in place to further the design, adaptation and facilities available.

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

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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were not enough staff, deployed effectively to meet people's needs safely.

People's risks were not always suitably assessed, monitored and managed to help keep them safe.

Medicines were not always safely managed.

Staff knew how to recognise and report abuse, however, the systems in place meant the provider could not be confident that nay potential abuse or neglect would be identified and reported.

People were protected from the spread of infection.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff teams and services did not always work well together to provide effective care because handover systems in place were inconsistent and not always productive.

People's nutritional risks were not managed well and they did not always receive the support they needed to eat and drink and timely manner. However, people enjoyed the food on offer.

People were supported to consent to their care, however, when a decision was to be made in a person's best interests, these were not always recorded.

People's needs were met by the design and adaptation of the home.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People did not always access to the emotional support they required because staff did not have time to spend with them.

People's dignity was not always respected and promoted.

People told us staff were friendly and kind to them. We saw some positive interactions between people and staff.

People told and we saw their privacy was respected and people at Churnet Lodge had the opportunity to retain their independence as much as possible.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive personalised care that was responsive to their needs because staff did not always know their needs and preferences.

Some people enjoyed activities on offer, however improvements were needed to ensure that all people had access to activities that interested and engaged them.

People felt able to complain if required and there was suitable complaints policy.

No-one was receiving end of life care at the time of the inspection but people's wishes about their care at the end of their life had been sought.

Is the service well-led?

Inadequate

The service was not well-led.

There was a registered manager but people did not always know who they were.

Governance systems were not operated effectively to check and improve the quality and safety of the services provided.

There was a lack of management and clinical oversight. The provider was unaware of many of the issues we found during the inspection.

Not all staff felt valued, engaged and involved in the development of the service.

Barrowhill Hall

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 regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 20, 21 and 28 August 2018 and was unannounced.

The inspection team consisted of three inspectors, an assistant inspector, a specialist advisor who was a nurse with experience of providing nursing care to older people and an expert by experience who has personal experience of caring for someone who uses this type of care service.

Before the inspection visit, we checked the information we held about the service and provider. This included the statutory notifications that the provider had sent us. A statutory notification is information about important events which the provider is required to send us by law. We also reviewed information we had received from the public, commissioners of the service and the local authority. We used this information to help formulate our inspection plan.

We spoke with seven people who used the service and three visiting relatives. We did this to gain people's views about the care and to check that standards of care were being met. We also spoke with 14 members of care staff, three nurses, two activities staff and a visiting healthcare professional. We spoke with the deputy manager, the registered manager and the provider to help us to understand how the service was managed.

Some people who used the service were not able to speak with us about their care experiences so we observed how the staff interacted with people in communal areas and we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We looked at the care records of 13 people who used the service, to see if their records were accurate and up to date. We also looked at records relating to the management of the service. These included six staff files, staff rotas, training records and quality assurance records.

Inadequate

Is the service safe?

Our findings

At the last inspection, the service was rated as requires improvement in this area because there were issues identified with the management of medicines. There were no breaches of regulations but improvements were required. At this inspection we found the required improvements had not been made and there were further concerns identified.

People told us and our observations confirmed there were not always enough staff available to meet people's needs. One person said, "You have to shout. Usually they come fairly quickly but not always." We saw the lack of available staff impacted on the care and support people received and people had to wait for the support they needed. For example, morning medicines at Churnet Lodge were not completed until 13.00, which had a knock-on effect to the timings of medicines throughout the day and meant there was a risk of people not receiving their medicines as prescribed or not having an adequate time period in between doses. One person was served their breakfast and a cup of tea but sat alone for 45 minutes with their breakfast untouched and their tea going cold, no-one offered support to this person and their lunch then arrived and the breakfast was removed. This showed staff were not always available to provide the support people needed. We saw communal areas were left without staff presence at times which impacted on people's safety. One person was coughing at the dining table and the inspector had to alert staff to this as there were no staff available to assist this person. We saw another person moving chairs around in the dining room and they took one person's frame from them and placed it in the corridor. This posed a risk to other people and there were no staff available to observe people and ensure that their safety was maintained.

Agency staff were used to cover staff shortages. The provider told us this was due to holiday periods and whilst they recruited more staff. We found some agency staff had not arrived at work on the day of our inspection visit, however management were unaware until we told them about this. This meant there was not an effective system to ensure that enough staff were present in the home to safely support people. We told the provider about our concerns with staffing levels and on the second day of inspection there were more staff on shift. However, there were still insufficient staff to keep people safe and meet their needs. We saw that one person was being assisted to eat but was left half way through their meal for seven minutes whilst the staff member left to deliver a meal to another person. We also observed and heard people at lunch saying, "We've been here an hour waiting, what's the point" and "There's a lot of coming and going and no doing."

At Dove House there were two staff members available to support the ten people who lived on this unit. Some of those people were nursed in bed and required two staff to support them to reposition or with personal care. Staff told us, and our observations confirmed, that when the two staff were supporting a person in their bedroom, this left no other staff available on the unit to support other people in the lounge, or their bedrooms, or respond to emergency call bells. We observed periods of up to fifteen minutes when there were no staff available as they were busy supporting people in their rooms. Some people had sensor mats to alert staff of their movements due to high falls risk but staff were not always available to respond quickly to these alerts. This left people at risk of harm. There was a system in place where staff should call

downstairs to ask for another member of staff to 'cover the lounge' before supporting people to reposition. However, we saw this did not always happen and staff reported to us that this system did not work because staff were not always available downstairs to cover the lounge. A staff member said, "I have phoned downstairs before and they are too busy to help. That [system] should go in the bin." Although the staffing levels for the whole home had increased on the second day we saw there were still not enough staff to support people to stay safe and meet their needs.

Staff told us they did not feel there was enough of them to safely meet people's needs. One staff member said, "You have to prioritise who needs care first because you can't get to everyone as soon as they need it." Another said, "It worries me as we need to try and keep people safe but low staffing impacts on this. I think it has got worse recently." Staff told us they had communicated their concerns to the registered manager and provider but that nothing had changed. A staff member said, "The staffing is ridiculous. Some staff are very stressed. We have told them [registered manager and provider] but nothing changes. It's not fair. They have a set number of staff decided but they don't consider the time it takes to deliver person-centred care." A visiting health professional said, "There's not enough of them [staff]. Everyone is running around like headless chickens." The provider told us they were working on an improved 'dependency tool' to help them assess safe staffing levels in the home, based on people's needs and risks, however this work was not fully completed and the registered manager and deputy manager had little knowledge of it. Agency staff were being used regularly to increase staff numbers, however the deputy manager was unable to confirm to us that the required number of agency staff had been booked and confirmed to ensure there were enough staff present in the home to support people safely and effectively.

The above evidence demonstrates that there were not always sufficient numbers of staff, effectively deployed to meet people's needs. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's risks were not always effectively managed to keep them safe and well. Some people were at risk of developing pressure sores and some people had wounds to their skin. We found that wounds were not always consistently managed to reduce risks of further deterioration and promote healing. For example, one person had a wound but there was no wound care plan in place. There was a wound chart which showed the treatment delivered. However, it showed that inconsistent dressings had been used and there was no clear plan of the care and treatment required to promote healing and reduce the risk of further deterioration. A nurse told us, "I had not seen the wound before I dressed it. There is just a wound chart, there is no acute care plan and it's a nasty wound." This meant there was a risk of the person receiving inconsistent care to manage the wound because there was no clear plan in place. The deputy manager told us on the third day of the inspection that a referral to a tissue viability nurse was required for specialist assessment and advice, however this had not been completed and the person had developed another wound. This meant the person's risk of skin damage had not been suitably assessed, monitored and managed.

Staff were not always aware of people's risks and how to keep them safe. For example, one person received one to one care to mitigate their high risk of falls. An agency staff member was providing one to one care but they were unable to tell us about the person's risks and needs. We asked if a nearby walking frame belonged to the person and they were unaware whether the person required a walking frame to help them walk safely or not. This showed that the staff member responsible for supporting the person was unaware of their needs and risks.

Some people were at risk of malnutrition and dehydration and required their food and fluids to be monitored to ensure they received an adequate amount to keep them healthy and reduce risks to their

health and wellbeing. We found that one person had lost weight but there were no recorded actions being taken to support the person to maintain a healthy weight. Other people had fluid monitoring charts in place but there was no system in place to check whether they were receiving adequate amounts of fluids. The deputy manager told us, "No-one checks the daily fluid totals." This meant that although a risk had been identified and fluid monitoring had been implemented, there was no system to monitor this and ensure any required action was taken such as encouraging more drinks or referring to a doctor.

People who displayed behaviours which may challenge services were at risk of receiving inconsistent care and support. We observed a person in the lounge area shouting at staff and other people who used the service. We saw staff were recording regular behaviours which challenged on monitoring forms. However, there was no behaviour care plan or risk assessment in place to ensure that staff had guidance on how to support this person. This meant the person was at risk of receiving inconsistent support to manage their behaviours as staff did not have clear guidance in place about what may trigger the persons behaviour or how to respond to manage risks to themselves and other people who used the service. This risk was increased by the regular use of agency staff who did not know people well. We told the provider about this concern and a behaviour assessment and care plan was implemented. However, it stated that staff needed to be aware of triggers. It did not state what these individual triggers were. We asked a senior member of staff to show us where the triggers would be recorded and this information could not be located. This meant people were still at risk of receiving inconsistent support.

People told us they received their medicines when they required them. One person, who told us they experienced frequent headaches said, "How can I put it, the [staff] have the tablets, I take two tablets with water and after five minutes the pain is gone. They check on you to see if the pain is gone." However, the provider had not always ensured the proper and safe use of medicines. We found over 3000 tablets in a plastic bag in the corner of the treatment room. The registered manager and nurse on duty did not know about these and told us they did not know where they had come from. There were also a high number of bottled medicines, creams, blister backs containing medicines, the prescription labels had been removed so we were unable to reliably tell who the medicines belonged to and why they were being stored in a box on the treatment room floor. The registered manager later told us they had ascertained the medicines were due for disposal. They told us the night nurse had prepared them for disposal however there were no disposal bins due to a change in supplier. They showed us returns records from April 2018 onwards and said they felt these would tally with the medicines that were found. However, this was not safe practice because it does not comply with guidance about the safe storage and prompt disposal of medicines and showed the home did not have a safe and consistent system and procedure in place to ensure medicines were stored and managed safely.

Some people were prescribed 'as required' (PRN) medicines. However, the guidance in place for staff was not detailed to ensure the staff member knew when to administer these medicines to ensure they were used consistently and not overused. For example, one person was prescribed an anti-anxiety medicine 'as required'. The PRN protocol stated it should be administered for 'agitation'. There was no further detail as to what strategies should be tried before resorting to medicines administration or at what point the medicines should be administered. The Medicine Administration Record (MAR) showed this person received this 'as required' medicine twice a day, every day, which was not as the prescriber intended. There was no evidence that the prescriber had been asked to review this medicine or the person's agitation. The nurse told us that this medicine should have been reviewed but it had not been. This meant there was a risk that the person was not receiving their medicines in the way the prescribing doctor intended.

Some people's medicines were administered covertly (administered in a disguised form without the person knowing). Medicines should only be administered covertly in exceptional circumstances and when this has

been agreed to be in the person's best interests. We saw that one person's medicines were administered covertly without clear involvement of the prescribing doctor or pharmacist. There was a care plan for administration of covert medicines. However, this was not dated, nor was the accompanying mental capacity assessment or best interests' decision which meant we could not be sure this was completed before covert administration commenced and could not be sure the decision had been regularly reviewed. None of the documents recorded details of others involvement including GP, Pharmacist or family. One of the person's medicines had a specific instruction that it was not to be crushed. The deputy manager told us this particular medicine was not given covertly but this detail was not included in the care plan. The care plan referred to, "accordance with the GP and pharmacist instruction and documentation." However, the deputy manager confirmed this documentation was not available. This meant that the safe and proper use of medicines had not been ensured.

We found other examples which showed that medicines were not always safely managed. We found creams in people's bedrooms which were not prescribed for them, they had other people's names on the prescription labels, we found a syringe containing medicine in a communal area that staff were unable to account for, recorded stock balances did not always match what was actually in stock, prescribed thickener was kept in communal areas which people living with dementia could freely access, and audits of medicines had not identified any of the issues we found.

The above evidence demonstrates that people did not always receive safe care and treatment. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they knew how to protect people from abuse and they had received training in safeguarding adults. Referrals had been made to the local safeguarding adults team in line with safeguarding adults procedures when concerns had been identified. However, there was a lack of clinical oversight of people's needs and risks which meant that concerns may not always be identified in a timely manner. For example, the lack of review of behaviour charts, daily records or repositioning charts meant that potential neglect or abuse may not be recognised and reported in a timely way. This meant there was a risk that concerns about people's care and treatment may not be highlighted and therefore the systems and processes in place were not robust to ensure that people were consistently protected from potential abuse or avoidable harm.

The registered manager told us that one person was known to, "alleviate the truth at times" and had been known to say things had happened that were later found to be untrue. However, there was no care plan or risk assessment in place in relation to this. This meant there was a risk that the person may make allegations against staff that were false. There was also a risk that staff may assume the person was not telling the truth, should they raise any concerns. There was no clear plan about how to support this person when they raised concerns or made allegations which meant neither them or staff were consistently safeguarded. It also meant that lessons had not been learned and improvements made when things had gone wrong to reduce the risk of a similar incident occurring again.

People told us and we saw that the home was clean and tidy to help protect people from the spread of infection. We observed that staff wore personal protective equipment to help prevent the spread of infection. We saw domestic staff carrying out cleaning duties and a regular infection control audit ensured that any issues in relation to infection control were rectified.

Requires Improvement

Is the service effective?

Our findings

At the last inspection the service required improvement because the Mental Capacity Act 2005 was not always consistently followed, though there were no breaches of regulations. At this inspection we found that improvements were still required.

People consented to their care when they were able to. We saw that staff sought people's consent before supporting them. 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff we spoke with had an understanding of the MCA and were aware of their responsibilities in supporting people's decision making. One staff member said, "Everyone is deemed to have capacity unless it is proved otherwise, capacity is decision specific." We found that people's capacity to consent to their care had been assessed when required. However, specific best interest's decisions were not always recorded. For example, we found that some people had bed rails which they lacked the capacity to consent to. There was no record to show that a best interests discussion had taken place to ensure that this was the least restrictive option to keep the person safe. Another person had experienced seizures but had received no medical investigation into the reasons for this. The deputy manager told us that family members held the legal decision-making power to make this decision on behalf of the person but they had not asked for evidence to show this legal power. We advised this evidence should be obtained and staff then discovered that family did not hold this power. There was no record of a best interest discussion in line with the MCA. We told the provider about our concerns and they told us they would arrange a best interests meeting with the relevant parties as soon as practically possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are 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 were being met. We found that DoLS authorisations had been requested when these were required.

Staff teams did not always work effectively together as handovers were not effective in ensuring that all staff had the information they needed about changes in people's needs and risks. One person told us they had to wait for their medicines because staff were unaware they had returned to the home following a visit. We looked at the handover records and found that specific information about the person was not recorded, including that they had returned to the home. A visiting healthcare professional told us, "I don't think there's much of a handover because I'll say something on a Monday or Tuesday and by Wednesday it has not happened. It means that things are not happening as quickly as they should. It's been lucky because there is a risk that if something is not treated as quickly as it should be, it could end in hospitalisation." We also saw that handovers were not consistent as some staff were using electronic records and others were not. Information about people was kept in different places, some electronic and some paper so it made it

difficult for staff to know the most up to date and relevant information.

All relevant staff were not involved in handovers. For example, on Dove House, staff told us and records confirmed there was no nurse input into handovers despite people requiring nursing care. This meant there was no clinical oversight of people's risks including wounds and nutritional intake. We saw that activities coordinators helped with supporting people to eat they were not involved in handovers so there was a risk that changes in people's eating and drinking needs would be missed. The deputy manager explained to us the handover process, however we observed and staff told us, this process was not actually happening. We gave feedback about our concerns to the deputy manager and they told us, "Maybe we need a handover sheet." These examples showed that improvements were needed to the way in which staff worked together to ensure that effective support was delivered.

People were not always supported to eat and drink enough to maintain a healthy diet because nutritional risks were not always suitably managed. One person was identified as at risk of malnutrition. They were prescribed nutritional supplements which they were receiving however, despite the deputy manager telling us all meals were fortified, we found the person was often given sandwiches which were not a fortified meal and records showed they were not always given snacks to boost their nutritional intake. We saw the person had juice and crisps next to them in their bedroom but they were unable to eat these independently. Another person was seen by a dietician due to a high risk of malnutrition. Their care plan stated they should be weighed weekly to help monitor this risk. However, staff told us no one required weekly weight monitoring and we found they had not been weighed weekly to monitor their risk.

People told us they enjoyed the food on offer and had choices of food. One person said, "It's nice. You can choose between one thing and another." Another person said, "If I don't like the lunch they will try to facilitate." However, we saw that some people did not experience a positive lunch time experience because they had to wait for support to eat. One person had to wait for support to eat their meal and when it arrived, they said, "It [meal] is a bit cold." We saw that an individual who was on work experience was asked to support a person to eat their meal. The person on work experience had received no training and was supporting a person who had a specialist diet and care plan in place for their eating and drinking. This meant that people did not always receive effective support to eat and drink.
People's needs were assessed before they moved to the service. However, improvements were required to some assessments to ensure that care and treatment was provided in line with current standards and guidance. For example, one person displayed some behaviours which challenged the service, however their needs in relation to this had not been assessed and there was no care plan in place to provide staff with the guidance on how to support the person. We told the provider about our concerns in this area and they told us they would ensure that necessary assessments and corresponding plans of care were in place.

Staff received training to help equip them with the knowledge and skills to provide effective support. Staff told us and records confirmed they had received training including safe moving and handling, dementia care, safeguarding adults and equality and diversity. Staff we spoke with were able to demonstrate their knowledge. A staff member said, "We have training updates annually and I have done train the trainer (a course to enable staff to train others)." Staff had mixed opinions about whether they were supported in their roles. One staff member said, "I feel fully supported and I can ask any questions I have." We saw that some staff had received supervision which gave them an opportunity to discuss any training needs or worries and get feedback on their performance. However, we found that not all staff had received supervision and therefore did not feel fully supported. One staff member said, "I have never received any supervision. I assume the registered manager is my supervisor but I don't really know." This meant that staff were not always clear about how to access the support they needed to deliver effective care. The registered manager confirmed that not all staff had received supervision because they had fallen behind with this task. We also

found that agency staff did not always have an induction into the home which included information about the needs of the people they were supporting. This meant they were not fully equipped to deliver effective care.

People told us they had access to healthcare professionals. One person said, "I'm going to the dentist soon to have a tooth out. I had an ulcer that was infected and they arranged for me to go to the orthodontist at the hospital, a carer came with me." Records showed that people had access to a range of professionals. However, the lack of clinical oversight at the home meant there was a risk that the need for healthcare professional input may not be recognised in a timely manner and therefore this may delay people's access to healthcare support. For example, the lack of fluid monitoring meant that the need for professional advice may not be identified and the lack of wound treatment plans meant that the need for tissue viability specialist advice may not be recognised.

People's needs were met by the design and adaptation of the building. There were accessible bathrooms so that people's personal care needs could be met effectively. We saw that coloured doors in Barrowhill Hall were used to help people living with dementia to identify bathrooms and their bedrooms. Some people had personal information or photographs at their bedroom doors to help them identify their personal space however this was not consistent for all. The provider had plans in place to make further improvements to the environment by introducing a dementia friendly garden.

Requires Improvement

Is the service caring?

Our findings

At the last inspection we found the service was caring. At this inspection we found that improvements were required.

We saw and staff confirmed that they did not always have the time they would like to spend with people to provide emotional support. One staff member said, "I love them all [people who used the service] but I cannot spend the time I would like with them, talking and paying attention in that way, I just keep going and hope this will improve." We observed one person appeared agitated and attempted to stand up 16 times in half an hour. Each time they stood, a staff member redirected them to their seat and offered no distraction or interaction because they were rushed and were focused on tasks and could offer no positive engagement. Later we saw another staff member came into the lounge and started to engage with the person and they visibly calmed; this was 35 minutes after the person had first shown signs of agitation. This meant people did not always have access to emotional support and reassurance when they needed it.

People's dignity was not always respected and promoted. We heard care staff referring to people in a task focussed way by saying, "I've got [Person's name] to do, will you go and do [Person name]?" This discussion took place in a communal area where people could hear the discussion about others. This meant that people's privacy and dignity was not consistently respected. We observed that one person had faeces on their quilt despite having received care and support from staff in the morning, this was not dignified for the person.

We observed that some people were offered choices but this was not consistent for everyone. One person told us, "We usually get orange but I like water." We observed that some people were offered choices of meals and drinks but others were served without being offered a choice. The service supported people living with dementia and although menus were available, there were no visual aids to support people in making an informed choice. People were not consistently supported to express their views and be involved in decisions about their care. One person told us, "Sometimes I want to do things, I try to tell them, they do listen usually but not always. Sometimes it's too difficult for them." People were not routinely involved in developing and reviewing their own plans of care which meant their views were not always heard. This meant that improvements were required to the way in which people were involved in making decisions about their care and treatment as far as possible.

People told us that staff were friendly and caring towards them. People's comments included, "They [staff] are nice, they're friendly", "It's not too bad here, there's a nice atmosphere, if you need any help they are always willing to help you" and "It's a bit like home." Another person said, "I choose to be here because the carers really go the extra mile for me, they really do care." A relative said, "My relative loves it here. I wouldn't dream of them moving, even though I have to travel 45 minutes each way every day to see them. They [staff] are very caring and I trust them to give [my relative] the best care." We observed some caring interactions between people and staff. For example, one person was living with dementia and took a wet wipes container from a member of staff. The staff member showed sensitivity and gently closed the lid to make it safe for the person to keep hold of. The staff member said, "It wouldn't have hurt to have it open but they are

wet and slippery and it is safer to have it closed, to hold." Later, once the person had finished with the container the staff member discreetly put it away. This showed kindness and sensitivity to the person's needs and respected their dignity.

People told us their privacy and independence was respected and encouraged. One person said, "All the staff are respectful and knock before coming into my room". Another person said, "I choose to keep my door locked as other residents wander in." We saw that people were given this choice and it was respected by staff to ensure people had privacy when they wanted it. One person told us, "I can just help myself to drinks and breakfast cereal, they make my toast for me." We saw on Churnet Lodge that people had access to a kitchen area where they could make their own drinks and snacks and that people used this to help retain their independence.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection we found the service was responsive. At this inspection we found that improvements were required.

People did not consistently receive personalised care that was responsive to their needs. There were a lot of agency staff supporting people and they did not always know people's needs and preferences. We asked an agency staff member who they had been supporting. They showed us a piece of paper with four room numbers written down and we asked them how they knew about those people and what support they needed. They told us, "I know by their attitude. I have been given these [people] because they are not aggressive. I don't have a care plan to look at but I just know by their attitude." This did not support person-centred care delivery. However, we found that regular staff knew people well. A staff member said, "[Person] likes whiskey after tea. They can get a bit emotional, so I sit with [Person]." This showed that some staff did know people well and catered for their preferences, however improvements were required to ensure this was consistent.

There were dedicated activities staff employed and working at the time of the inspection. However, we saw that they often supported people with care needs rather than activities. We did not observe any planned activities. At times, we saw that activities staff members were the only staff in lounges to supervise people's safety and support them to eat which meant they did not have time to support people to follow their interests or engage in social activity. People had mixed views about the activities available to them. One person said, "When the craft people come I join in. We made baskets last time, I enjoyed that. I'd like to make cards sometime, I hope I will get to do it." Another person said, "I don't like the activities on offer, I might choose fishing or to go to the pub." Records showed that activities took place including movement sessions, crafts and some people visited local attractions including cafes. An activities programme was planned and included events such as cabaret singers, outings to local attractions and visits from local school children. However, a staff member told us, "Activities are limited at present. They mainly happen with people who are able to participate but not others who may be more difficult to stimulate." We also found that many people were nursed in bed or stayed in their rooms with the door closed. It was not always clear if this was by choice and some people appeared isolated with little opportunity for meaningful engagement or interaction. For example, one person's care plan stated they were able to get out of bed and into a wheelchair, however we saw they stayed in bed and staff were unable to explain why the person had not got out of bed. This meant that improvements were required to ensure people had access to meaningful activity or interaction that they enjoyed.

People had an assessment before they joined the service. We found that people's diverse needs including religion and sexuality were discussed with them as part of the assessment process. Some people had communication needs and we saw that specific communication plans were in place for people which included any specialist requirements they had to aid their communication. For example, one person required large print books and support to read their correspondence. This ensured that people's diverse needs were assessed and met.

People told us they would feel able to raise concerns and complaints if they needed to. One person said, "If I have a problem I ask a senior carer to help as they are the best to ask if you want something to be done." There was a suitable complaints policy in place to ensure people's complaints were listened to and appropriate action taken. However, the registered manager was unable to locate complaints records for us to view. The provider later told us that last year's complaints records had been archived. They were unable to locate any formal written complaints for 2018 and the registered manager said they could not recall any. People told us their complaints were listened to and responded to but improvements were needed to the systems in place to ensure that appropriate action was recorded to ensure lessons were learned from complaints and improvements were made when necessary.

At the time of the inspection no-one was receiving end of life care. However, we saw that people had plans in place to consider how they would like to be supported when the time came. We looked at a person's advance care plan and saw that their family had been consulted because they were unable to share their own views. Other professionals had been involved in planning the persons end of life care including a specialist palliative care service to ensure that plans were in place to help the person be supported to have a comfortable and pain free experience at the end of their life. The home was also participating in a project with a local hospice to try to help improve people's experiences, by having improved advanced care planning.

Inadequate

Is the service well-led?

Our findings

At the last inspection we found the service was well-led. At this inspection we found serious concerns.

There was a registered manager in post, which is a requirement of the home's registration with us. However, there was a lack of management and clinical oversight of people's needs and risks which affected the quality and safety of the care people received.

Governance systems in place were not operated effectively to continually assess, monitor and improve the quality and safety of the services provided.

The deputy manager told us that monthly audits of pressure sores, weights and medicines were completed. There were no recorded audits of other aspects of care such as care plans, daily records or monitoring charts including food and fluids. This meant that quality and effectiveness of these records and care delivery were not reviewed and action was not taken to drive improvements and manage risks. For example, some people had daily target fluid goals because of identified risks. There was no system for regularly checking their fluid records to ensure they had reached their target amount or to take action to encourage increased fluids or seek medical attention if required. There were also no audits of repositioning charts which meant the management team could not be sure that people were getting the care and support they needed to manage their risks. This meant there was no effective system in place to assess and monitor people's risks.

Medicines audits were completed monthly but did not identify the issues that we did during the inspection. For example, protocols for 'as required' medicines lacked detail so there was a risk that people would not receive their medicines as prescribed. Stocks of medicines were not consistently and effectively monitored. Covert medicines were being administered without the necessary permissions and involvement of the GP and Pharmacist. The August 2018 medicines audit had not identified any issues or areas of improvement which showed it was ineffective.

A monthly pressure sores audit completed in July 2018 did not include all people who had pressure damage to their skin. It also did not detail the actions being taken to manage the ongoing risks to people. This meant that it was not effective in identifying, managing and monitoring risks.

A monthly weight loss audit was last completed July 2018. Three people had weight loss over 3kg recorded. There were no recorded actions. We also found other people had lost weight and this had not been captured on the monthly audit and no action had been taken. Some people had not been weighed regularly with reasons recorded such as, "equipment missing" and "unable due to stairs". A member of staff told us that they were unable to weigh some people as the scales were not working. When we bought this to their attention, the provider found the scales were in working order but had not been charged. However, due to the lack of clinical oversight, this issue had not been identified prior to the inspection which meant that some people had not been weighed and no action was being taken to address this. These issues meant the systems in place to manage and monitor service users' risk of weight loss were ineffective and the leadership at the home was ineffective in identifying and rectifying issues which affected the management of people's

known risks.

The provider told us that care plans were reviewed on the electronic care planning system, however these were not always effective as they did not identify the issues that we did during the inspection. We identified that numerous care plans contained conflicting information that was confusing for staff and resulted in people being exposed to risk of receiving inconsistent care and support. This risk was heightened by the regular use of agency staff who were unfamiliar with people's needs and risks. The registered manager agreed with our findings that some care plans were contradictory because of the way the electronic system had been used. They said, "I went to alter a care plan following a SALT (Speech and Language Therapy) assessment and I found it contradictory as the old entries had not been struck through. [The care plan] had been evaluated but the old entry was still there so it wasn't clear." We found that some people's care plans continued to be contradictory. The registered manager knew about this issue but had taken no action to stop this from happening again. They knew that agency staff were regularly used at the current time which increased the risk of people receiving inconsistent or incorrect care for their needs because care records were not clear, yet they had still taken no action.

Staff were still adjusting to the introduction of a new electronic care planning system at the home. Some people still had paper care plans in place and others' records were fully electronic which made it more difficult to access the information staff needed. There was a project lead for the introduction of the new system who checked that staff were completing records on the electronic system. However, their role did not include identifying or taking action against clinical risks such as low fluid intake, they were supporting staff to ensure accurate recording. Whilst this supported staff, it did not contribute to the monitoring or management of people risks or the quality of care delivered.

The above evidence demonstrates that systems and processes were not established or operated effectively to ensure that people received a good quality and safe service. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We told the provider about the concerns we identified during the inspection and they took a number of actions to help improve the safety of the care people received. However, further improvements were required to ensure people received a good quality service.

People and relatives were not always clear about who the registered manager was and did not always see them regularly. One person said, "I have only seen the manager once in the year I have been here, I have asked to see them twice but they didn't come, one of the problems resolved itself in the end." Staff did not always feel valued and supported by the registered manager and management team. One staff member said, "Management never come through the door and have no idea what is going on." Another staff member said, "I'd like a management team that are supportive and actually know the residents. They don't help us." This meant there was not a positive and inclusive culture where staff felt empowered to deliver high quality care.

The service did not always use the opportunity to continuously learn and improve because the culture within the staff team did not support this. For example, we found a syringe filled with medicine in a communal area of the home. When we asked staff, they were unable to reliably identify where it had come from and why it was there. Staff had neither noticed nor taken action to check whether someone had missed their medicine dose, to ensure it was stored securely or to safely dispose of the medicine to remove the risk of other people accessing it. Until we brought this to the attention of the registered manager, no action or investigation was being carried out because the issue had not been identified.

Staff did not always feel engaged and involved in the running and development of the service. A staff member said, "There was a staff meeting about four weeks ago but it was just a telling off about now using the electronic system properly. I've never had a supervision, a questionnaire or an opportunity to give any feedback." Another staff member said, "We tried staff meetings once per month but I can't remember the last one. We work together well as a staff team but there are members of the management team that don't get things resolved." The registered manager told us, "We have daily 'stand up' meetings but we have not been doing them recently. We also have staff meetings but we are behind with them." We found that the management team were not involved in the daily handovers and they explained the handover system to us, though staff explained a different process which meant they were not aware of how things were actually working in the day to day running of the home. The provider showed us records of three staff meetings which had taken place since December 2017. They also told us about an online staff forum which all staff could access to raise any feedback or concerns. Some staff gave positive feedback about this but improvements were needed to ensure that all staff felt valued, engaged and involved with the service. People and relatives were given the opportunity to feedback in an annual questionnaire. We saw the result of this had been analysed and people's comments had been responded to.

The service worked in partnership with other agencies including a local school to help build links with the local community. They were also working with a local hospice to help improve the care and support people experienced at the end of their lives. However, the provider needed to ensure the service worked in partnership with professionals and commissioners to improve the standard of care people received. We had received statutory notifications of certain important events that the provider is required by law to notify us of.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not always receive safe and care and treatment because their risks were not always suitably assessed, monitored and managed. Medicines were not safely managed.

The enforcement action we took:

We imposed a condition on the provider's registration which required them to send us a monthly summary of the action that they have taken to ensure that risks are managed.

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 Governance systems in place were not operated effectively to continually assess, monitor and improve the quality and safety of the services provided.

The enforcement action we took:

We imposed a condition on the provider's registration to require them to send monthly updates to us about what governance systems are in place and how these are working to improve the quality and safety of services.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff, effectively deployed to meet people's needs and keep them safe.

The enforcement action we took:

We urgently imposed conditions on the provider's registration to say they must complete a thorough review of all service users' holistic care needs and risks to develop a dependency tool to calculate the staffing levels required within the home.
They must ensure that sufficient numbers of staff are deployed to safely meet people's identified care and support needs. They must update us weekly about this.