Barham Care Centre Limited

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Inspection report

Church Lane
Barham
Suffolk
IP6 0PS
Tel: 01473 830247
Website:

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

This inspection took place on the 5 August 2015 and was unannounced.

Barham Care Centre is a care home with nursing which provides accommodation and support to older people and those living with dementia and other specialist care needs. The service is registered to accommodate a maximum of 34 people. On the day of our inspection there were 27 People living at the service.

The service had a registered manager. 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.

Whilst the service carried out risk assessments which identified people at risk of falls, malnutrition and acquiring pressure ulcers there was insufficient guidance with actions for staff to take in monitoring and mitigating risks to people's health, welfare and safety.

We found medicines were stored safely for the protection of people who used the service. However, the

Summary of findings

management of people's medicines was found to be inconsistent in ensuring people received their medicines as prescribed and assessed to ensure they received their medicines according to their needs, wishes and preferences.

People were treated with kindness, compassion and respect and staff protected people's right to privacy.

People were protected from the risk of abuse as staff had received training, understood how to respond and report appropriately where they had concerns. Risks to people had been assessed but care planning with guidance and actions for staff was limited in planning to mitigate the risks to people from pressure ulcers.

There was no effective system in place to record that checks of call bells had been carried out. We were therefore not assured that steps had been taken to ensure people were able to summon help at all times if they needed it.

Staff received training in recognising abuse and were able to describe various types of abuse and how they would respond if they had concerns. The registered manager understood the responsibilities of their registration with the Care Quality Commission (CQC) and local safeguarding protocols in accordance with the requirements of their registration.

Feedback was sought from people and their relatives and used to improve the care people received. People knew how to make a formal complaint and complaints were taken seriously and addressed in a timely manner.

Summary of findings

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 consistently safe because the management of people's medicines was found to be inconsistent.

People were protected from the risk of abuse as staff had received training, understood how to respond and report appropriately where they had concerns.

Risk to people had been assessed but care planning with guidance and actions for staff was limited in planning to mitigate the risks to people from pressure ulcers.

Requires improvement

Is the service effective?

The service was not consistently effective because there was ineffective monitoring and planning for people at risk to ensure their nutritional and hydration needs were met.

Staff received supervision and training, however further work was needed to provide all staff with training in prevention from the risk of malnutrition and from the risk of pressure ulcers.

Requires improvement

Is the service caring?

The service was caring as staff were attentive to people's needs.

People were treated with dignity and respect.

Good

Is the service responsive?

The service was responsive because Care staff were knowledgeable about the care needs of the people they supported. They demonstrated their understanding of the needs of people living with dementia.

People were occupied and supported with a range of social and leisure activities. This included maintaining links with the local community.

Good

Is the service well-led?

The service was well led because processes were in place to monitor the quality of the service and action planned with timescales when it was identified that improvements were required.

Good

Barham Care Centre Limited

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 was planned to check 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 the 5 August 2015 and was unannounced.

The inspection team consisted of one inspector and one expert by experience with experience in health and social care services. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Prior to our inspection we reviewed the information we held about the service. We looked at statutory notifications the manager had sent us and information received from relatives and other agencies involved in people's care. A statutory notification is information about important events which the service is required to send us by law.

During our inspection we spoke with five relatives, the provider, the manager, one domestic, four care staff, a nurse and a nursing assistant. We also spoke with two administrators.

We reviewed three people's care plans and checked records as to how they were cared for and supported. We reviewed three staff files to check staff had been recruited, trained and supported to deliver care and support appropriate to people's needs. We reviewed management records of the checks the manager and provider had carried out to ensure themselves that people received a quality and safe service. This included a review of records in relation to the management of people's medicines.

Requires improvement

Is the service safe?

Our findings

Staff used a computerised risk assessment tool to monitor risks to people's safety. These records included personalised risk assessments for each person and guidance describing actions for staff to take to reduce the risk of harm to people. These included the risks associated with people being assisted to mobilise around the service, the risk of falling and the risk of them developing pressure ulcers. However, these were not detailed enough. Safe and appropriate monitoring of skin integrity involves management monitoring of continence, the provision of pressure relieving equipment and a regular change of position to protect people from developing pressure ulcers. Where people had been assessed as at high risk of developing pressure ulcers we found there was limited and unclear guidance for staff in the steps they should take to monitor and mitigate the risks to people. For example, two people assessed as at 'very high' risk of developing pressure ulcers, their care plan guided staff to reposition every two to four hours. There was a lack of recorded evidence to assure us that repositioning had taken place within the regularity described. Some people had hourly check monitoring forms and others at risk did not. Monitoring forms had significant gaps between staff recording when support had been provided with repositioning to prevent pressure areas developing. Staff were confused as to where they should record and when. For example, whether to record on paper 'hourly check' records or the computerised care records system or both. We were therefore not assured that steps had been taken to provide staff with sufficient guidance and clear action plans in place to mitigate the risks to people's health, welfare and safety.

One person being cared for in bed told us they had been ringing their call bell for assistance but none of the staff had responded. We checked their call bell and found that it was not plugged in properly to enable activation of the call bell to alert staff. We asked the manager what if any systems there were in place to regularly monitor call bells to check they were operating effectively. They told us that domestic staff were expected to check call bells were working when they cleaned a room. However, there was no system in place to record that checks of call bells had been carried out. We were therefore not assured that steps had been taken to ensure people were able to summon help at all times if they needed it.

This demonstrated a breach of Regulation 12(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found medicines were stored safely for the protection of people who used the service. However, the management of people's medicines was found to be inconsistent. Several of the Medication Administration Records (MAR) did not include a photograph of the person for whom medicines had been prescribed. This was particularly significant as nursing staff from another service covered for staff absences and who may not be familiar with the people living at the service.

There was a lack of profiles which would described what medicines people had been prescribed, the reasons for their being prescribed and if people had been asked their preferences as to how they would choose to take their medicines. This included a lack of guidance for staff where people had been prescribed 'as and when required' medicines PRN for example, pain relief or to aid sleep. One person told us, "I have a lot of pain especially first thing in the morning. I ask for them [staff] to bring me tablets to take away the pain but they sometimes forget and don't come back when they say they will. I rely on them to do what they say they will."

Staff did not routinely record the dose given when a variable does was prescribed, such as when a person was prescribed medicines to aid pain relief which could be given as one or two tablets. We found for one person pain relief medicine prescribed had not been recorded on the MAR record. This meant we were unable to balance the items of stock against the MAR records.

We carried out a check of stock against MAR records for five people. We found discrepancies against four items of medicines where the number of tablets remaining did not balance with the records of receipt and administration. This meant that people may not have received their medicines as prescribed.

We reported our finding to the manager who said immediate action would be taken to improve the safe and proper management of medicines.

This demonstrated a breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service safe?

People told us they felt safe living at the service. One person told us, "I feel secure living here. I couldn't be better looked after. I think they're [staff] trained well but there are not enough of them. Sometimes it's dinner-time before everyone's up." Another said, "I have no concerns other than some staff are better than others. By that I mean there are some I would much prefer to have help me. Some are a bit brusque in their manner but others are good and otherwise I am not concerned."

People had mixed views about whether or not there were enough staff on duty. Some people told us, "Yes, there are enough staff. They come when you call" and "I think there are enough staff about." Whilst others told us, "There are not enough staff sometimes and you have to wait for your tablets." Another said, "Staffing varies. They don't always have time to chat rushing here and there." One relative told us, "I would say that most of the time there are enough staff there is the odd occasion when they appear short."

On the day of our inspection one nurse, one nursing assistant and and one domestic staff member had called in that morning to say they would be absent due to illness. This meant that the nurse who had worked the night shift stayed on to cover until the manager had been able to arrange for a nurse from another home run locally by the provider to cover. We observed this to impact on the ability of nursing staff to ensure that people received their morning medicines in a timely manner. However, we also observed there to be sufficient numbers of staff throughout the rest of the day to support people to eat their meals one to one and responding to call bells in a timely manner.

We reviewed the staffing rota for the last month. We found that the rota did not always fully reflect the actual staff who had worked and the actual hours worked. Where changes had been made to provide staff cover for shortages of staff the actual staff including the manager providing this cover were not always recorded. We discussed this with the manager who told us they would rectify this as a matter of urgency.

Staff told us they had received training in recognising abuse and were able to talk about various types of abuse. All said they would report poor practice to the management and demonstrated knowledge of how to contact other safeguarding authorities.

There was a system in place to ensure safe recruitment procedures were followed when recruiting new staff. Checks had been carried out before staff started work to make sure that they had the required skills and were suitable to care for people. This included checks on people's identity, employment history and checks using the Disclosure and Barring Service (DBS) prior to staff being appointed.

Requires improvement

Is the service effective?

Our findings

People and their relatives told us that staff had the skills to care for them. One person told us, "I think they are trained I do not see anything to tell me they are not." One relative told us, "The staff appear trained to me."

Staff told us they had received induction training when they first starting working at the service which included opportunities to shadow more experienced staff.

Staff, which included nursing staff, told us and records confirmed that they received a range of training which helped them to meet people's needs within a nursing care environment and keep them safe. However, a review of the provider's training matrix which recorded the training staff had attended, showed that only not all nursing staff had received up to date training in pressure ulcer care and prevention and the use of malnutrition screening tools to assess people at risk of malnutrition and supporting people's nutritional and hydration needs. Staff told us they were confident in meeting people's needs but would welcome further training to provide them with further skills and knowledge to carry out the roles they were employed to perform.

Staff told us, and records confirmed that staff had access to regular one to one supervision sessions with either the manager or senior staff. This meant that staff had regular opportunities to discuss their professional development and any issues relating to the care of people who lived at the service.

People told us they were offered choices as to what time they got up in the morning and what clothes they wore. One person said, "They show you what choice there is of what to wear and I choose what I want." We observed staff asking people for their consent before providing any care or support to them.

Staff and the manager demonstrated their understanding of their legal roles and responsibilities with regards to the Mental Capacity Act (MCA) 2005 and associated Deprivation of Liberty Safeguards (DoLS). Systems were in place to make sure the rights of people who may lack capacity to make decisions about their everyday lives had been assessed and protected. The manager had taken action as is required by law to request urgent authorisation from the local safeguarding authority where people's freedom of movement had been restricted in their best interests and to keep them safe from harm. However, care plans contained limited information with regards to the assessment of people's mental capacity to make decisions about their everyday lives and to evidence that they had consented to their care and treatment.

We received mixed feedback from people and their relatives about the quality and variety of the food provided. Overall people told us that the food was to their liking but others were less complimentary. Comments received included, "If you don't like it they give you what you do like", "The food's not bad, not keen, but it's edible I suppose", "The food is excellent, I have no complaints" and "I don't like the ready prepared meals, it is not what I would have chosen but it's what you get. Not what I am used to, I prefer fresh home cooked food." One relative told us, "There is a lack of fresh fruit and vegetables, it's all frozen food, not fresh food. Not what [my relative] would have been used to."

We observed the experiences of people whilst eating their meals. The midday meal was served in the conservatory for one group of people and in another room which included a lounge and dining area. Although meals were cooked and prepared on the premises we saw that people's individual needs and wishes were being catered for, including specialised diets. Staff were attentive to people and the meal time experience was unhurried with sufficient staff available to support people who required one to one support to eat their meal.

People, who had chosen to, remained in their rooms to eat their meals. Where required, people had been provided with supportive equipment such as plate guards which enabled them to eat and drink independently. People were provided with a constant supply of drink to ensure they were supported to be hydrated. However, where some people remained in their rooms there was insufficient recording of the amounts of fluid they had consumed within a 24 hour period. Where staff had recorded people's fluid intake on the computer care recording system and where this had flagged up where people had consumed insufficient amounts of fluid throughout the day, there was no recorded action in response to mitigate the risks to these people. We were therefore not assured that action had been taken to ensure that people were sufficiently hydrated to meet their health and welfare needs.

The care records we reviewed recorded people's weight. Where people's needs had changed. For example, where

Requires improvement

Is the service effective?

they had experienced weight loss, appropriate referrals had been made for specialist advice and support to the dietician. People's nutritional assessments showed that food first principles of adding cream shots and providing milkshakes were being used, as well as prescribed supplements. However, where people had been assessed as at risk of malnutrition and their food and fluid required monitoring, records did not always evidence the type of food and the quantities consumed. This had the potential to put people at risk of not having their food intake monitored sufficiently to meet their nutritional needs and maintain their health. We discussed this with the manager and they recognised the shortfalls and took action to inform staff of the need for more robust recording within care records.

We spoke with the chef on duty who told us that they were aware of the different nutritional requirements of people using the service. They showed us a list of people who were on specialised diets, including those who were on a diabetic diet or required a soft food.

We looked at a weekly menu planner which showed a varied and balanced range of meals, with options available at each meal. Biscuits were provided with drinks. However, the choice was limited and we observed that there were no other snacks other than biscuits available to people throughout the day. However, staff told us that snacks such as cakes, biscuits and crisps were available to people when they wanted them but was reliant on people asking. We discussed this with the manager and provider. They told us that it was unusual for snacks not to be ready available for people and they would rectify this immediately.

People were supported to maintain their health and wellbeing with access to healthcare professionals such as dieticians, chiropodists and GP's. Relative's told us they were kept informed as to any changes in the health and wellbeing of their relatives.

Good

Is the service caring?

Our findings

One relative told us, “I visit regularly ad always feel welcomed and there are no restrictions on visiting times.” One person using the service told us, “It may not be posh here but it’s homely and the staff are nice.”

Care staff provided support to people in a way that was caring and responsive to their needs. We observed staff provide care to people in a kind caring and at times affectionate manner.

One person told us, “There is a mix breed of staff some are kind, attentive and do what you ask and provide what you need when you need it. Other’s when you call say they will get you what you need but don’t come back. Some are a bit brusque in their manner but others very kind.” Another person told us, “They are all good and kind.” A relative told us, “[our relative] always looks clean and well dressed as they would have always wanted to be. It’s good to see that staff respect that.”

Staff employed to provide activities for people were observed to be sensitive to people’s limited physical abilities when supporting them with an exercise class, encouraging and affirming people throughout. These staff were also involved in supporting people with their meals and did this in a dignified manner, talking to people throughout and showed a good knowledge of people’s needs.

Staff interacted with people with warmth and in a respectful manner. We saw staff respond to choices people made about what time they wanted to get up, what they ate and staff explained what they were going to do prior to supporting people with personal care or with eating their meal. For example, we observed when one person who had become distressed and needed support with personal care. Staff approached the person in a calm manner and whilst taking them to their room reassured them and took action to ensure their privacy and dignity was respected. This engagement with people was respectful and mindful of their dignity.

People told us that staff protected their privacy and promoted their dignity when supporting them with personal care. One person told us, “They shut the door and help me to feel safe and not exposed when washing me in the mornings.”

Good

Is the service responsive?

Our findings

People told us they received the care and support they needed at the times they wanted it. One person said, "They're brilliant. It's not like a palace, but it is homely. They help me with my wash and look after my catheter. The staff pop in sometimes to my room and chat with me. I feel completely secure with the care I receive."

Electronic care plans had been developed from the information gathered during the initial assessment process and updated following a regular review. However, care plans were limited in their information when describing actions for staff to take where risks had been identified in relation to the risk of developing pressure ulcers. Care plans described and information was provided to kitchen staff which described people's wishes and preferences with regards to the foods they liked and disliked, allergies and how people chose to take their tea and coffee and preferences for cooked breakfasts.

The manager told us that care reviews were held on a regular basis for people to be involved in the review of their care and relatives or those of their choosing invited to be involved in the process. However, none of the people and relatives we spoke with told us they had been involved in these meetings.

Care staff were knowledgeable about the care needs of the people they supported. They demonstrated their understanding of the needs of people living with dementia and what to do when people became distressed and reacted in a way that may present a risk to themselves or others. Doll therapy used to enhance the wellbeing of people living with dementia was promoted in a meaningful way. We observed one person gain great comfort from being able to access dolls which they cuddled, changed the dolls clothes, talked to and had access to place dolls in a pram. Staff were sensitive to this persons needs and supported the person in this activity which clearly made the person happy and helped them to maintain a sense of contentment and wellbeing.

People were not limited in their access to various areas of the service and could easily access the garden. One person told us, "I enjoy being able to get out into the garden and so much better since they have nought us some nice garden furniture."

Activities organisers were employed to organise and provided a range of different activities, aimed at meeting people's individual needs and interests. These included, exercise classes, trips to the shops, drawing and painting, card making and music sessions. On person told us, "We've been out to the rare breed's farm and to the birds of prey centre and we enjoy the outings they provide. It gets you out and about and makes you feel good." Another told us, "We enjoyed a good day out to Felixstowe for tea, that was a good day. One relative told us, "The staff work very hard to make Christmas and New Year's eve a real celebration."

We observed an exercise class run by an activity organiser. This activity was organised to encourage people to exercise and improve their mobility. The activities organiser was sensitive to the needs of people and their limitations, affirming and encouraging them within this activity. Other activities were provided on a one to one basis, including activities for those people who preferred to stay in their rooms. These included hand massage, manicures and reading and discussing topics in the daily newspapers. This meant that people were provided with opportunities to access activities to pursue their leisure interests and activities that promoted their autonomy and community involvement.

Relative's told us they knew how to complain if they had concerns about the care provided. Residents and relatives meetings evidenced that people had been informed regarding any changes to the service and how to access the provider's formal complaints procedure. One person told us they had complained to the manager about the towels and facecloths not being available in the bathroom when they needed them. They said the manager had responded quickly to their request. A relative told us they had complained that their relative's toe nails had been left to get too long and that following raising their complaint with the manager this had been rectified promptly. We noted that this was also recorded within the provider's system for logging complaints.

Good

Is the service well-led?

Our findings

One relative told us, “The home is well run and [my relative] is happy here.” Another person told us, “I have had many conversations with the manager and if I am not happy they get it sorted straight away. I can talk to her and she listens. Nothing is too much trouble.”

Staff told us they found the manager, “Approachable”, “They help out when we are short of staff”, “If I have concerns they listen” and “I like working here and I enjoy what I do. I think the home is well run.” Staff told us the manager listened to and dealt with concerns they had in a supportive and constructive manner.

Staff had access to regular supervision and regular staff meetings where issues were discussed such as work performance, team work, training and planning for improvement of the service. For example, a discussion as to how to improve the standard of laundry service.

The provider was present during our inspection and told us they visited the service regularly. They also told us they had recently started to evidence the quality monitoring audits they carried out and sent us a copy of one recently recorded. This showed us that where shortfalls had been identified actions to drive improvements had been recorded with timescales for compliance. For example, it had been identified that moving and handling risk assessments needed to be reviewed and updated as well as a need for nursing staff to review skin integrity plans to ensure a record of equipment in place and a prevention plan was implemented.

Regular meetings were held with people and their relatives to discuss the quality of the care received and to update people with changes regarding the management of the service and future building plans to expand the service. We saw that concerns raised by people and shortfalls identified as a result of audits were discussed with staff at staff meetings. The provider told us they had recently sent surveys to relatives to obtain their views regarding the quality of the service.

We saw that the service had a four star rating with the Food standards agency (FSA) food hygiene safety rating. Five is the highest rating that can be awarded. Where shortfalls had been identified at the most recent FSA inspection the chef showed us where improvements had been made to protect people from the risks of inadequate food safety monitoring. For example, in the recording of cleaning carried out alongside effective cleaning schedules now in place

The registered manager understood the responsibilities of their registration with the Care Quality Commission (CQC) and local safeguarding protocols. They reported significant events to CQC, such as safety incidents, in accordance with the requirements of their registration.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014** **Safe care and treatment** **How the regulation was not being met**: The provider had not taken steps to ensure staff had the guidance they needed and effectively monitored people at risk of developing pressure ulcers. The provider did not have a system in place to evidence a check of call bells to ensure that people had access to working call bells when they required assistance from staff. **Regulation 12 (2)(a)(b)** The management of people's medicines was inconsistent. **Regulation 12(2)(g)**