Hallmark Healthcare (Holmewood) Limited

Barnfield Manor Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Barnfield Manor is a residential care home providing personal and nursing care to 21 people at the time of the inspection. The service can support up to 39 people. The service supports people across two floors in one building.

People's experience of using this service and what we found
People were not always protected from abuse as the systems and processes in place were not always effective in identifying incidents.

People were at risk of neglect due to the staffing levels within the location. Staff and relatives told us of incidents when people's personal care, emotional and medicines needs and had not been met in a timely manner as there was not enough staff available.

People, staff and visitors were not protected from risk of infection. We found that cleaning records for high touch areas had not been completed for the majority of September.

Risk to people had not been consistently assessed and medicines were not always safely managed.

Staff had been recruited safely and environmental risks were well managed.

Monitoring processes were not effective. Shortfalls in cleaning records and medicines management were not identified or actioned.

People and their relatives had regular opportunities to suggest improvements to the service through questionnaires and meetings with the manager.

Staff meetings regularly took place and staff told us communication is good.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; however systems in the service did not support this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 18 May 2018)

Why we inspected
The inspection was prompted in part due to concerns received about staffing levels. A decision was made

for us to inspect and examine those risks.

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

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to staffing levels, safeguarding, person centred care, safe care and treatment and governance. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

This service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

This service was not always well-led.

Details are in our well-led findings below.

Barnfield Manor Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014. As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Barnfield Manor is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager who had applied to become registered with CQC. This means that as well as the provider they will become legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the 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.
We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service and four relatives about their experience of the care provided. We spoke with nine members of staff including the regional director, regional manager, home manager, nurses, senior care assistants, care assistants and domestic staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and cleaning records.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

- People were not always protected from avoidable harm. We found three separate incidents which had been recorded but had not been reported to the provider or safeguarding authority. Measures had not been put in place to reduce the risk of re-occurrence. We raised this with the provider who followed this up by taking the necessary actions.
- People were at risk of pressure damage or infection from poor hygiene practices. Staff told us of incidents when people's personal care not been provided in a timely manner due to the staffing levels in this location. Staff told us they had raised this with the management team and nothing had changed.
- People were at risk of neglect as there was not enough staff available to meet people's individual needs. People and relatives told us of incidents where people's emotional needs had not been met due to the staff not being available. During the inspection we spent time with a person who we found in distress, we spent approximately 15 minutes with this person, during this time staff were not visible and did not attend.

People had not been protected from the risk of abuse. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Assessing risk, safety monitoring and management; Using medicines safely

- People's weights were not always monitored. The provider did not have a strategy in place to monitor people who could not or did not want to use weighing scales. This meant that any changes may not be identified or actioned. We raised this with the provider who informed us they will implement an alternative method.
- The provider had had failed to put control measures in place for a person who had been experiencing increased falls and periods of distress. The provider had referred the person to external agencies for additional support, however they had not put any immediate measures in place to meet the person's current needs.
- Risk to people had not been consistently assessed. External professionals told us they found some people's care plans did not reflect their current needs and associated risks in relation to moving and handling and diabetes. The provider had not been aware of this and had agreed to ensure these were updated.
- People were at risk of not receiving their prescribed medicines. We found that a counting system was not in place for regular medicines, staff told us there was not an effective ordering system in place and that they

often found that people had ran out of medicine, this meant that their time was often taken up arranging an ad hoc supply which took them away from their usual duties. We checked the medicine records and did not see any evidence to suggest that people had missed medication due to supply.

People were at risk of unsafe care and treatment. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff received training in medication and undertook regular refresher training. Staff received regular checks and direct observations of their practice to ensure medicines were administered safely.
● The service worked in partnership with other professionals to ensure people received their prescribed medicines as required. There was guidance for staff to follow for safe administration of 'as and when required medicines' (PRN).
● Environmental risks were well managed, regular checks had been carried out which included equipment checks and fire safety.

Staffing and recruitment
● People, staff and relatives consistently told us there was not enough staff to meet people's needs. Staff told us, "It can be hectic, we are so busy when we are providing personal care if the buzzers are going and we can't get there people have to wait" and a relative told us, " They are majorly understaffed, the call bell rings constantly."
● Not enough staff were deployed to meet people's needs. During the inspection we observed call bells to be ringing throughout a mealtime, staff were task focused serving food and cleaning and did not spend time to reassure a person who was in distress.
● Staff told us they required more staff on shift. The provider used a dependency tool to inform staffing levels, we found this tool did not consider the size or layout of the building.
● The manager told us they required four care assistants per day shift to meet the needs of the people living at Barnfield Manor. Rota's from 22 August to 16 September 2021 evidenced that on nine day shifts there were only two or three care assistants working.

The provider had failed to ensure enough staff were deployed to meet people's needs. This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Staff were recruited safely. The provider completed pre-employment checks such as references and Disclosure and Barring Service (DBS) checks. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with vulnerable adults, to help employers make safer recruitment decisions.

Preventing and controlling infection
● People, staff and visitors were not protected from risk of infection. We found that cleaning records for high touch areas had not been completed for the majority of September. We raised this with the provider who told us they would ensure that daily checks of the records would be carried out.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.
We have also signposted the provider to resources to develop their approach.

Learning lessons when things go wrong
● The manager and provider's quality team had identified that improvements were required to the safety and quality of the service. There was a plan in place however not all the timescales of the plan had not been met and required review.
● The provider acted promptly by telling us the actions they would take to address the findings of our inspection.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- People's individual needs had not been consistently recorded. External professionals told us that they had identified people's lifestyle choices had not always been included in their care plans or followed. This meant that people had not received person centred care.
- We observed staff to be kind and caring throughout the inspection, however staff told us they were concerned that they did not have time to listen and talk to people. Relatives told us, "The staff are very caring, there is just not enough of them, [person] just doesn't feel anyone cares or is bothered. No one does any activities."
- We observed that staff did not have time to engage in activities with people. We completed a Short Observational Framework for Inspection (SOFI) during the inspection and observed that staff were caring but task focussed. The provider told us they were actively recruiting an activities coordinator to improve people's experiences.
- People's social interaction needs were not always met. We identified a person who was permanently cared for in bed, the person's care record stated social interactions should be completed twice daily, the record had been completed twice in September 2021. This meant the provider had not ensured the person's care needs had been met.

The provider had failed to meet people's person-centred care needs. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Systems and processes to protect people from abuse were not always effective. The provider regularly analysed accidents and incidents to identify trends and patterns, however they had not identified the safeguarding incidents we found during this inspection.
- Processes were not effective at monitoring or identifying shortfalls in cleaning records and the medication system to ensue gaps were identified and actioned.
- The provider had not put any follow up actions in place following five incidents which posed a risk to staff. We saw no evidence that lessons had been learnt to prevent any future incidents.

Systems were not robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care; 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 manager and provider's quality team had a quality improvement plan in place, however the plan required a review as not all the timescales had been met.

● Complaints about the service were well managed. We reviewed the complaints the service had received, we found these had been investigated and promptly resolved.

● The provider understood their responsibility to keep people informed when incidents happen, however they had not always identified areas of the service that required improvement.

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

● The manager had a supervision schedule in place to ensure all staff had a regular one to one meeting. Staff told us they had regular supervisions and most staff felt supported in their roles but felt they did not have enough time to spend with people..

● People and their relatives had regular opportunities to suggest improvements to the service through questionnaires and meetings with the manager. We saw evidence that the provider had actioned feedback they had received in relation to visiting arrangements.

● Staff meetings regularly took place. Staff told us, "Communication is good, we are a small team you get to find out what is happening and what has happened."

Working in partnership with others

● The service worked in partnership with other professionals such as GP's and speech and language therapists to support people to access healthcare when they needed it.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to meet people's person centred care needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's weights were not always monitored and adequate control measures were not in place for a person whose care needs had changed. Risks to people had not been consistently assessed and people were at risk of not receiving their prescribed medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not robust enough to demonstrate safety was effectively managed

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from the risk of abuse.

The enforcement action we took:

We issued a Warning Notice for the provider to be compliant by 10 March 2022