Mr & Mrs P Gungaloo

The Barn House

Inspection report

Quality street
Merstham
Redhill
Surrey
RH1 3BB
Tel: 01737643273

Date of inspection visit: 16 July 2015
Date of publication: 08/10/2015

Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**

Overall summary

The Barn House provides care and accommodation for up to 30 people and is registered to provide nursing care for people with physical disabilities, mental health issues and those who may be living with dementia. On the day of our inspection 23 people were living at the service.

We carried out an unannounced comprehensive inspection of this service on 21 April 2015. After that inspection we received concerns in relation to the risk management and safety of people. As a result we undertook a focused inspection on 16 July 2015 to look into those concerns. This report only covers our findings in relation to this topic.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for (location's name) on our website at www.cqc.org.uk

The service is run by a registered manager, who was present on the day of the inspection visit. 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 and associated Regulations about how the service is run.

Staff did not have written information about risks to people and how to manage these in order to keep people safe. One person had a high risk of falls; other people had behaviours that challenged others. Risk assessments and care plans did not reflect the individual need of the person and how their mental health and physical needs affected their daily life or how the service managed the risks to the person or others.

Staff recruitment processes since our last inspection had not been robust. The provider had not undertaken the appropriate checks to ensure new management and nursing staff were recruited properly.

The provider had not undertaken the appropriate assessments to ensure the planning of care balanced the needs and safety of people with their rights and

Summary of findings

preferences. The registered manager had not undertaken appropriate risk assessments prior to people moving into the home to ensure that staff had enough information to support the person.

The provider and registered manager had not notified the relevant authorities about incidents that affected the health, safety and welfare of people. Notifications of incidents had not been submitted to CQC as required by law.

New staff were not appropriately supervised when they were learning new skills.

The provider and registered manager had not always protected people from abuse and improper treatment or actively worked with others to ensure that care and treatment remained safe for people. They did not have systems in place to investigate or respond without delay to the issues identified.

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?

Inadequate 

The service was not safe.

Risks to people's health and welfare were not minimised effectively.

The provider had not carried out appropriate checks to help ensure they employed suitable people to work at the service.

The provider had not undertaken the appropriate assessments to ensure the planning of care balanced the needs and safety of people with their rights and preferences.

The provider had not notified the relevant authorities about incidents that affected the health, safety and welfare of people. Notifications of incidents had not been submitted to CQC as required by law.

The provider and registered manager had not always protected people from abuse and improper treatment or actively worked with others to ensure that care and treatment remained safe for people.

The Barn House

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 focused inspection was undertaken due to concerns we had received and 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.

The inspection took place on 16 July 2015 and was unannounced. The inspection was carried out by two inspectors.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR) because we were responding to information and concerns that had been raised with us. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law.

We looked at documents which included four people's care plans and risk assessments, two staff files, training programmes, four weeks of duty rotas, three- monthly accident analysis reports completed by provider and quality assurance records. We also looked at a range of the provider's policy documents. We asked the registered manager to send us some additional information following our visit, which they did not do.

During the inspection we spoke with seven people who used the service, seven staff, the registered manager, the registered provider, the newly appointed manager and health care professionals. We observed care and support in communal areas and looked around all areas of the service.

We last inspected The Barn House on 21 April 2015 where breaches in the regulations were identified.

Inadequate

Is the service safe?

Our findings

People on the whole said that they felt safe. One person said, “Safe? Yes. They test the fire alarm and we go outside”. Another person pointed to an emergency call bell on the wall in the first floor dining room and said, “I’ve got one in my room but I don’t know what to do with it. They are fitted in all places around here”. When asked if they felt safe from harm a third person said, “I have everything I need in my room. Occasionally if needed I go to the office and talk. They sort things out.”

Although people told us they felt safe we found that risks to people had not always been managed safely or recorded appropriately. One person was at risk of falling and had sustained injuries as a result which the provider was aware of. This person was a mentioned two accident reports but the summary did not include any further information about how accidents could be avoided. A falls chart was in place but this had inaccurate information on it.

Risk assessments had not been updated regularly. One persons moving and handling assessment stated ‘mobility is deteriorating’ however there had been no action taken to review this risk more regularly. No action had been taken to mitigate the risk whilst specialist advice was sought.

We observed another person in the garden who was exhibiting behaviour that challenged such as turning over garden benches and banging on the windows. They were left in the garden for 15 minutes with no staff present to supervise them. We looked at this persons care plan and noted that the behaviour charts were logs of incidents that had happened. There was no documentation in place to determine how staff should try to reduce the anxiety to the person or manage their behaviours that challenged others. We asked three staff members what they knew about the person and how to manage risks and the staff were unable to tell us any information.

Some peoples call bells were unplugged which meant they would be unable to summon help if necessary. Staff had not regularly checked on them to ensure they were safe and we had task the provider to resolve this. We looked at the observation records for one person. These showed that hourly observations were to take place between the hours of 8am to 8pm and two hourly from 9pm to 7am. However on there were significant gaps for days in April and May and two days in July the records were incomplete and did not evidence that the checks had taken place. This showed us that staff were not providing the appropriate checks or equipment to the person to ensure their safety or enable someone who had limited mobility to summon help if they needed it.

Some people had been assessed as being at risk of losing weight or not drinking enough. The provider told us that there was only one person who had lost weight. This persons care plan did not reflect the nutritional support provided or give clear guidance to staff. Another person’s risk assessment stated “X food need to be cut up they have to be fed which takes more than half an hour” and “The person has to be fed both food and fluid.” The home had not assessed them for the risk of choking or followed the local authority Choking Prevention Policy. We spoke to the registered manager about this who was unaware of the local authority guidance.

People were not receiving enough to drink. We checked the fluid charts for the five people who had them, and saw that they had not been filled in on a regular basis. One person’s chart had not been completed for a period of three days. The charts that had been completed showed that not all people were being supported to have the correct amount of fluid; for example one person only had 200ml fluid on the 12 July and another person only had 800ml of fluid on the 15 July. The recommended guidelines from the Royal College of Nursing, Water for Health Hydration Best Practice Toolkit for older adults is that daily intake of fluids should not be less than 1.6 litres per day. We saw that drinks were not in reach of people in their rooms. One person lips were very dry and they asked us if we could give them a drink, which we did. This put people at risk of becoming dehydrated.

We asked one of the providers about management systems for recording, assessing and taking prompt action to reduce risks to people. They showed us the accident summaries from February 2015 to May 2015. There was no systems in place to monitor accidents or injuries or identify trends.

The provider and registered manager had not appropriately reported to the local authority safeguarding team or to CQC incidents that had happened or submitted notifications in a timely manner. We asked one of the providers if there had been any incidents or events at the home since our last inspection that had resulted in the

Inadequate

Is the service safe?

submission of statutory notifications to us. They told us of two events. There was no evidence of investigation into how these injuries had occurred or that they had been reported to the local authority safeguarding team.

The provider and registered manager did not have a robust system for investigating, monitoring and implementing actions to reduce the risk to people and have oversight and scrutiny of safeguarding within the setting. They had not followed guidance of their own policy which states; 'All reports of abuse no matter how minor , should be immediately investigated and acted upon by the person in charge'.

The provider had not ensured there were enough sufficiently skilled or trained staff to meet peoples care and support needs. People who lived at the home and staff that we spoke with said that on the whole there were sufficient staff deployed on each shift to meet people's individual needs. One person said, "They are usually pretty regular. They are not often late with things". A member of staff said, "It would be good to have more staff. Sometimes older people need more time and we have to rush".

On the day of the inspection we were greeted at the door by a nurse who had only started the day before. We were asked to wait as we were told the registered manager was not in the building. We waited for approximately 20 minutes and were then greeted by the provider who had been in the building the whole time. We asked the provider why the new staff member was not being supervised and were told that "We were only in a meeting." This meant that the home was being overseen by a nurse who was still undertaking induction.

The provider said that some nursing staff have recently been dismissed from employment and they are currently recruiting new staff. We asked the provider if the nursing staff that had been dismissed had been appropriately referred to the Nursing and Midwifery Council. We are waiting for information to confirm this from the provider.

The provider explained that due to nurse vacancies they were the allocated nurse on duty on days when this role was not covered by permanent nursing staff. They said, "I like to be on the floor as it gives me a good indication how people are cared for. I do induction of staff, most of the supervision, questionnaires and organise training. I supervise how to do care plans and risk assessments'. With regard to how staffing levels were decided the provider said, "These are decided by myself and my husband. I don't see an issue with the levels."

The registered manager said "Because we don't have any high dependency people the staff levels are adequate for the care we give. The majority of people are minimum assistance. We are going to implement an assessment tool. We don't use agency staff. If someone is off sick we always get covered, there have not been any gaps. We try to have a member of staff in the lounge area, it can be me with my files, even with handovers a staff or member of management is present".

One registered nurse said that they had worked the previous night shift; they had then returned to duty at 4pm and were working until 8am the next morning.

The experience and skill mix of staff that we spoke with varied. A care assistant told us that this was their first job in the care sector. The nurse who was on induction was a registered mental health nurse. The provider had not carried out appropriate checks to help ensure they employed suitable people to work at the service. We looked at the recruitment records for the two newest people who had commenced employment since our last inspection. One did not include evidence that a check had been made with the Disclosure and Barring Service or any proof of identification. One of the providers said, "They brought this in today but she did not have time to copy due to the inspection and she has taken it home." The second contained only one reference and this was not from their last employer. We were informed that this had been obtained and that it must have been misfiled. We instructed the provider to supply documentary evidence of both of the missing documentation within 24 hours of our inspection. The provider did not supply this information which meant we cannot be sure the staff are being recruited safely.

People were not protected against the risk of unsafe care or treatment. This is a breach of Regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **People were not protected against the risk of unsafe care or treatment.**