Choiceclassic Limited

Barton Park Nursing Home

Inspection report

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Date of inspection visit:
05 July 2018
06 July 2018
25 July 2018

Date of publication:
11 September 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 of Barton Park Nursing home took place on 5 and 6 July 2018. We completed a further visit at the home on 25 July 2018 to check recent concerns which had been brought to our attention, however we found that these concerns were being addressed appropriately, however we have asked for information from the manager around timescales for completion.

The inspection was unannounced, and was undertaken both due to concerns being raised to us by the local authority.

We completed a focused inspection in April 2018, as we wanted to ensure the home was being managed appropriately, and we had been made aware of a change to the registered manager.

During this inspection in April 2018 we looked at the Safe and Well-led domains and found a breach in relation to the fire doors. We escalated our findings to the Merseyside Fire and Rescue service.

We received information from the registered manager after our inspection in April 2018 ended to confirm that the concerns we found in relation to fire doors had been rectified.

However, we saw during this inspection, that the service was still in breach of regulations in relation to this, and we escalated our findings from this inspection in relation to the fire safety of the home to Merseyside Fire and Rescue service. Merseyside Fire and Rescue service conducted their own inspection of the premises and found concerns relating to some of the fire safety of Barton Park. We have been updated with regards to this.

CQC have closely monitored the home since the since a criminal investigation began in relation to directors of the registered provider, Choiceclassic Ltd. We have been unable to report on this aspect of the inspection under the Well-Led domain due to reporting restrictions being in place. Following this verdict, CQC has followed their own regulatory processes to ensure the safe running of the home. This included imposing conditions on the registered provider's registration to prevent the directors from entering Barton Park or engaging in the regulated activity of the home. Following this inspection we have imposed a further condition that restricts the service from admitting any new service users given the concerns that we found.

Barton Park is located in Birkdale and is registered to provide nursing care and accommodation for up to 60 people. At the time of our inspection there were 14 people living at the home. This was because the local authority commissioning team had served 28 days' notice to terminate their contract with the registered provider, Choiceclassic Ltd in light of the guilty verdict of one their directors. On the last day of the inspection only six people lived at Barton Park.

Barton Park is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided,

and both were looked at during this inspection.

During day one of our inspection, there was a registered manager in post. However, by day two of our inspection the registered manager had been changed, and the deputy manager was on leave, which left a new manager who had started in post the same day as the overall decision maker of the home.

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.

We were concerned about this, as there was also no Nominated Individual (person responsible) in post to provide oversight and support with decision making in light of the restrictions on the registration of the directors of Choiceclassic Ltd. The new manager had only taken up post that day, and was not well informed as to the situation at Barton Park with regards the local authority issuing notice on their contract with Choiceclassic Ltd. Subsequently, this meant that people who received local authority funded care provision were being assessed for a place in other nursing homes. Additionally, the new manager had no induction or shadowing opportunity. Staff were also unaware of the changes to the management structure and staff members told us they were unsure what was happening or who they should go to.

Audits had not been completed when required. There was a dignity audit which was due to be completed quarterly, which meant it was due at the end of April 2018. This had not been completed. We saw that medication audits had not been completed since March 2018, therefore the service was unable to demonstrate a good oversight in relation to checking service provision. Governance systems in place also did not pick up on the concerns we found throughout our inspection. Additionally, the breach of regulation in relation to fire safety at the last inspection had not been adequately addressed, which demonstrated that lessons had not been learned from previous shortfalls and addressed or followed up appropriately.

The home was not adequately staffed which we saw during the second day of our inspection. The operation decision to change the registered manager at short notice meant that the nursing provision for the home over the weekend was not covered. This was because the previous registered manager had placed themselves on these shifts. We were concerned about this. Staffing rotas could not be located, and the new manager and HR manager were not sure what shifts needed to be covered. Due to the potential impact this could have for people living at the home, we shared our concerns with the local authority, and requested to be updated throughout the duration of our inspection until the shifts were covered. The new manger covered the shifts with a registered nurse who worked at the home and kept us updated of this.

There were other staffing concerns which we saw during our inspection in relation to supervision and appraisal. There was no documented evidence to show that staff had been engaging in regular supervisions. Three staff supervisions had taken place in 2018, however the rest of the supervisions were from 2017, and we could not determine which staff had been supervised and which hadn't. We also saw that most staff had not had an appraisal.

We found that medication was not always managed safely. This was because medications requiring cold storage were kept in a fridge, and the temperature had not been taken since April 2018. If medication is not stored within the correct temperature range its ability to work effectively can be compromised

Additionally, the process for administering Controlled Drugs (CDs) was unsafe and not in line with best practice. We have shared some guidance with the new manager around this to ensure they took action and

put adequate safeguards in place.

People's records were disorganised and often contained confusing information. Some care plans were not always clear, and risk assessments for some people had not been reviewed regularly. There were also gaps in the recording of information for some people, such as cream charts and pressure relief charts.

We were made aware by the local authority that some people's next of kin was still named as the director who had just been found guilty and sentenced for acts of fraud against people who had lived at Barton Park. Some of the financial information for people had not been made readily available for assessment by social workers and advocates when requested. The local authority shared this information with Merseyside police. This meant that people had not been safeguarded appropriately from potential acts of abuse.

The service was not always working in accordance with the principles of the Mental Capacity Act 2005. This was because information around people's decision-making abilities was not always clear. Additionally, some people's capacity had not been assessed as part of their admission to the home. One person's Deprivation of Liberty Safeguard (DoLS) authorisation had expired last year, and had not been reapplied for, nor had their capacity been reassessed.

We looked at the process in place to record and respond to complaints. There was no record of any complaints being received at Barton Park. However, one visiting relative told us they had made a complaint some weeks ago in writing and not had a response. We followed this up and saw there was no record of this complaint. Therefore, we could not be sure whether any other complaints had been received and not acted upon.

Care plans were basic in their presentation; however, they did have details with regards to people's likes, dislikes and routines. Due to the care records being disorganised, it was difficult to determine from the records if people were in receipt of person centred care. Person centred means care which is based around the needs of the person and not the service. Our observations showed that staff knew people well, and they could clearly explain their routines to us. However, some recording of information was lacking in detail for some people and detailed for others, which did not demonstrate a consistent approach to record keeping.

Staff recruitment records showed that most checks had been undertaken as needed. This included references, identification, and a Disclosure and Barring Service checks. We did see some recruitment files did not contain medical questionnaires or interview notes, whereas others did. This meant that recruitment records did not contain consistent information. We raised this at the time of our inspection and have made a recommendation about this.

We saw on day two of our inspection that there was a singing activity organised which people enjoyed. However, when we asked about other activities people could not remember what they had done, and one person said, "Not much happens in the home." On day one of our inspection we observed there was not much going on for people to keep them engaged, and most people sat in their room or in the lounge area. We have made a recommendation with regards to this.

A visiting family member and a person who lived at the home told us they felt safe with the level of care provided by the staff. One person however, was moving their relative out of the home because they felt they were not encouraged enough to leave their room and were isolated.

We checked the provision for food at Barton Park. This was because we had had concerns raised with us prior to our inspection that the registered provider was unable pay for items of food and stocks had run low.

We checked this, and saw that a food delivery had taken place. We also spoke with the chef who confirmed there was no change to the amount of food they were able to order. We checked the menu and saw people were given to choices of main course each meal and a pudding.

We are currently taking action against this provider which we will report on in due course.

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.

Fridge temperatures had not been recorded since April 2018. Additionally, the controlled drugs process was not safe and in line with best practice guidelines.

There was not enough nursing provision on day one of our inspection and rotas showed there were shifts not suitably covered.

People's care records were missing information and it was difficult to determine from records if the care provided was correct.

People were not always safeguarded against acts of abuse due to Next of Kin details not being amended.

The fire doors were still being wedged open in areas of the home which would present serious risk to people if there was a fire.

Is the service effective?

Requires Improvement

The service was not always effective.

The principles of the Mental Capacity Act 2005 (MCA) were not always being followed in the home. One person's DoLs had expired, and it was sometimes difficult to tell from mental capacity assessments what decisions people could make.

Staff were not regularly supervised and most had not had a yearly appraisal.

There was enough food at the home to ensure people had a choice of meals.

Our conversations with staff evidenced that referrals had been made appropriately, however these were not always recorded.

Is the service caring?

Requires Improvement

The service was not always caring.

The issues we found at the home with regards to the oversight did not demonstrate a caring approach from the registered provider.

We received positive comments regarding the caring nature of the staff team, most of whom had been working at Barton Park for a long time, and had good relationships with people.

Observations of staff interacting with people was positive and caring. It was clear staff enjoyed supporting people and cared about them.

People were making use of advocacy service and this Information was available in communal hallway of the home.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Complaints had not been managed and responded to in accordance with the registered provider's complaints policy.

There was information in care plans with regards to people's likes, dislikes and backgrounds. However, the level of information differed from person to person, and we had to ask staff with regards to some people's clinical needs as there was very little information recorded.

There were no scheduled activities taking place. We observed one activity but people generally said there was not much going on to keep them occupied.

Is the service well-led?

Inadequate

The service was not well-led.

There was a registered manager on day one of our inspection, however they were dismissed on the morning of day two of our inspection.

The new manager had no previous knowledge of Barton Park and was unsure where information was kept.

The current criminal investigation with regards to one of the directors of Choiceclassic Ltd had concluded. They were found guilty of charges of fraud relating to people who lived at the home. The other directors still have conditions on their registration preventing them from entering the home. This meant that there was still no provider oversight at the home, and there

was no nominated individual in post.

Some audits and checks had not been completed since April 2018 which should have been completed monthly. There was no one registered with CQC who was responsible for checking the provision of the service.

Staff said they felt unsure of what was going on at the home, and said they did not who to go to with their concerns.

Barton Park Nursing Home

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.

We inspected this service because we had received some information of concern form the local authority with regards to people's health and well-being. The local authority had been visiting the home regularly to help people transition to new homes and assess people who wished to move from Barton Park. Some of these areas of concern included, mental capacity, financial information, and care planning. We also decided to inspect Barton Park following the guilty verdict of one of the directors of Choiceclassic Ltd. Choiceclassic Ltd is the registered provider of the location, Barton Park. CQC has been aware of this ongoing police investigation which involved the directors Barton Park. One of the trials for one of the directors had concluded, however, the trials for the remaining directors were due to take place later in the year. CQC has not been able to include any information with regards to this in their past reports for Barton Park due to their being a reporting restriction in place. CQC have, however, used their powers to issue conditions on the registered providers registration to prevent them entering the home.

Since we began inspecting this service there has been inconsistency with regards to the meeting of regulations. At the last focused inspection in April 2018, the home was in breach of regulation. The meant that the home was rated as 'requires improvement'.

In light of the concerns mentioned above, we conducted a comprehensive inspection over two days on 5 & 6 July 2018. The inspection was unannounced. Due to further information which was shared with us we visited the home unannounced on the 25 July 2018. These concerns were in relation to the hot water supply and the lack of food supplies at Barton Park. We specifically checked these concerns with the manager on 25 July 2018, however we found action was being taken with regard to the hot water, and there was enough food in the home.

The inspection team consisted of a total of three adult social care inspectors who attended on different days. An inspector and Inspection manager attended on 25 July 2018.

We did not request a PIR for this service. 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 carried out a Short Observational Framework for Inspection (SOFI). SOFI is a methodology we use to support us in understanding the experiences of people who are unable to provide feedback due to their cognitive or communication impairments.

We looked at records and related documentation for five people. Two staff recruitment records, spoke to five staff and two people who lived at the home. We also spoke to three visiting relatives, and one visiting healthcare professional. On day one of our inspection we spoke to the chef, the registered manager and deputy manager. On day two of our inspection we spoke to the new manager and the HR manager. We walked around the home and checked the general environment. We observed lunch on day one of our inspection. We communicated over the two days with the local authority and social workers who were at the home to ensure we shared information regarding the health and well-being of the people who still lived at Barton Park.

Inadequate

Is the service safe?

Our findings

During our last inspection in April 2018 we found the registered provider to be in breach of the regulation in relation to safe care and treatment. This was because some of the fire doors in the home were wedged open without automatic closures. We shared this information with fire service as we were concerned that people were not protected in the event of a fire occurring at Barton Park. The registered manager advised us after the inspection that this had been rectified.

We followed this up during this inspection. During day one of our inspection we saw that the doors leading into the kitchen, laundry room, and corridor were still being wedged open. We were concerned because the kitchen presented a higher risk area of fire, and if a fire was to start in this area, there was no way it could be contained. Therefore, it would spread rapidly and may cause considerable harm to people living at the home. We informed the registered manager of this during the inspection. When we returned on day two our inspection we saw that the same doors were still wedged open. This demonstrated that no action had been taken to attempt to correct this serious occurrence. Therefore, people remained at risk. We informed the manager on day two of our inspection and they took immediate action to correct this by closing the doors.

We also saw that weekly fire alarms had not been tested since 6 June 2018. One staff member said they could not remember the last time the alarm had been tested. We have shared all of this information with the fire service, as we are concerned that people's health and safety would be compromised. The fire service have since informed us that have visited the service and have identified some additional concerns that required the service to take action.
We also saw on day one of our inspection the lounge room window was propped open using a brick. We were concerned about this, because a person who lived at the home was sitting nearby, and we were concerned the brick could fall and injure them. We raised with straight away with the registered manager who removed the brick. The registered provider remains in breach of regulation 12 of the Health and Social Care act 2008 Regulated Activities Regulations 2014.

We checked the process in relation to the administration and storage of medication. We saw that medication administration record (MAR) charts were in place for people who lived at the home and they were completed accurately and in full. We spot checked some of the medications, which were in a 'bio-dose' system, and saw that all the stock was accounted for. Medication was stored securely in a locked trolley in a locked room. We did however, see that the trolley was left unlocked on one occasion, however the room was locked.

We checked the medication which required cold storage and needed to be kept in a dedicated medication fridge. We saw that the fridge contained a stock of medication, however, we saw that the fridge temperatures had not been recorded since 27 April 2018. Recording the temperatures of the medication fridge is important, because if medication is not stored within the correct temperature range its ability to work effectively can be compromised.

We checked the process in relation to controlled drugs. Controlled drugs are medications which have

additional safeguards placed in them under the Misuse of Drugs Act 1971. We looked at the controlled drugs book that the registered manager had in place and saw that all entries except one had two signatures as required. We queried the missing signature and why this was not documented. The nurse in charge described the process in place for witnessing controlled drugs administration, which consisted of the nurse working the day shift administering the drug, in this case it was a patch for pain. The nurse who was taking over that night would then sign as the second signature without witnessing the application of the patch. We sought additional guidance from a CQC pharmacist. They told us this was not best practice due to the second nurse not witnessing the application however signing anyway. We have since shared some guidance with the registered manager on day one of inspection, which was again shared with the new manager on day two of our inspection so they could immediately assess the risk and take action.

This was a breach of regulation 12 of the Health and Social Care act 2008 Regulated Activities Regulations 2014

We found there was enough care staff on duty in the home to ensure people's needs were met on both days of the inspection.

We asked about staff numbers for the over the weekend in relation to the nursing staff. This was because we had been made aware during day one of our inspection that some staff had left, and the registered manager was filling the missing shifts themselves. During day one and day two of our inspection an operational decision was taken to change the registered manager with a new one appointed the same day. Due to the registered manager not being available, this meant that there was no nursing provision in place from 2pm that day (second day of inspection), and over the weekend of 7 and 8 July 2018.

The new manager did not have a copy of the rota and was unsure which shifts would need to be covered, or who out of the staff team had left the home. This put people at high risk, as some of the people in the home had nursing provision needs which would require a registered nurse to be on duty at all times. Due to our concern for people's safety, we requested that these shifts were covered, and asked the manager to inform us within immediate timescales that this had been completed detailing the rest of the cover for that weekend in relation to nursing staff. This information was shared with other appropriate health and social care professionals to ensure there was a plan in place which would keep people safe from harm. The new manager managed to cover these shifts and shared their rotas with us as requested so we were assured that people's needs could be met.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 Regulated Activities Regulations 2014.

We checked the risk assessments for five people who lived at the home. We saw, in general, risk assessments were in place, and the information required to keep people safe was present. However, the recording, documenting and reviewing of this information was disorganised and very difficult for us to follow in places.

For example, we saw that one person's Waterlow score was incorrect. A Waterlow score (or Waterlow scale) gives an estimated risk for the development of a pressure sore in a given person. According to their care plan, this person had a grade two pressure ulcer which had not been accounted for in the scoring process. This meant that the score for the person was recorded incorrectly. Therefore, the person was not getting the right support to help manage their pressure areas which put them at risk of developing further skin breakdown. However, upon further examination of this person's care plan, we found out that the person did have a pressure ulcer, however it had healed and was no longer grade two. This was confusing, because the person had a wound care plan in place which did not specify this and was difficult to follow due to the

information not being clearly recorded.

The wound care plan for the same person did not specify what dressing was being used for this person. Records not being reflective of the person's needs means that staff would be unclear with regards to their current health condition. The last care plan review for this person said, "improving", however, did not say if the skin was intact or not. This meant that new staff or agency staff would not be able to tell from the information how to support this person correctly.

Additionally, for the same person we noticed gaps in records relating to pressure relieving equipment. The equipment, which was air flow mattress and pump needed to be checked daily. However, there were numerous occasions in June 2018 this had not be documented by staff. Therefore, we could not be sure from looking at records if this person had received pressure care relief as stated in their care plan.

We saw from looking at records that a referral to a dietician was made in April 2018 due to this person losing weight. However, there were no records to show that the referral had been followed up for this person since April 2018. The nurse in charge told us that the person had been prescribed fortified drinks, however, they did not like them. They did not know if there had been a further referral. There was no record of this in the person's records. This meant that clinical oversight with regards to the recording of this person's health care needs was poor.

We found another person had a wound on their body, and it was not specifically recorded in the person's care plans who was responsible for dressing the wound. We spoke to one of the nurses to find clarity on this, as the recording of this information was difficult to find. Not recording important information puts people at risk because other staff members will not realise that this person needs specific support or follow up appointments, in turn, leading to the person becoming very poorly.

In addition, this person was prescribed creams for their skin. We checked their records and saw numerous gaps in the recording of these creams. This meant that the staff had not been recording when the person had their cream applied, and there was no way for us to check other than to ask the staff. Also, we saw that the turning charts (to relieve the pressure on a specific area of a person's body) contained gaps between 2 July 2018 and 4 July 2018. The records did not clearly show that this person had had their position changed. These records had not been completed by staff, or checked by the nurse in charge. This meant that the person might not have had appropriate care delivered by staff, or could have developed further pressure wounds due to the lack of turning. We did ask the person and their family who assured us that staff always support them in the correct way. However, due to the documentation being so poorly recorded, we could not corroborate this.

We saw that another person had been prescribed thickened fluids to aid swallowing and prevent choking. Records we looked at were not clear with regard to which stage of thickened fluid the person had. This meant that the person was at risk of being given fluid which could make them choke lead to health complications. We spoke to the registered manager on day one of our inspection who informed us the person was prescribed stage three thickened fluids, but this was not recorded in the person's care plan. When we spoke to the staff they confirmed that this person had stage one fluids. The care records for this person had not be reviewed since May 2018, and they were supposed to be done monthly. This meant that important information, such as how they require their fluids, was not updated, recorded or documented clearly. Therefore, if new staff came to support that person, they would be unsure how to thicken the person's drinks, which could lead them to choke.

We found a falls risk assessment for one person which had initially been scored incorrectly, which meant

that the risk assessment was not accurate. The score was documented as 11 when it should have been 10 according to the assessment. This risk assessment had been in place since December 2017, and every month the review had been initialled and signed which demonstrated that the record had been reviewed, however the error was not detected by the person doing the review. This shows that records were not being checked properly for errors which placed people at additional risk of harm.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 Regulated Activities Regulations 2014.

Staff we spoke with were aware of safeguarding processes and told us they would not hesitate to raise concerns if the felt that someone was being harmed or abused. This including raising concerns with the local authority safeguarding team, the police, or whistleblowing externally to CQC. One staff member said, "I would always speak up if I needed too." Our records showed that there were no open safeguarding referrals for anyone who lived at Barton Park during the time of our inspection. However, we were concerned because some of the people who lived at Barton Park had no safeguards in place around their next of kin and financial information. Some of the financial information for people had not been made readily available for assessment by social workers and advocates when requested. The local authority shared this information with Merseyside police. This meant that people had not been safeguarded appropriately from potential acts of abuse. We were made aware that one of the directors who had been found guilty of fraud offences, was still named as next of kin for at least three people in the home. We requested additional information concerning this to ensure people are not subject harm and abuse.

Following our inspection on day's one and two we wrote to the provider on a number of occasions advising of the serious concerns we have in relation to the management of the service, staffing levels, and the services financial viability. Their response did lead us to believe that health, life and well-being of people was not at immediate risk of serious harm. However, some of the responses received lacked detail and some were not even appropriately responded to so we could ensure that people were safe from the risk associated with harm. Therefore, we served an urgent notice that prevented the provider from accepting any new admissions into the home.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 Regulated Activities Regulations 2014.

We checked the recruitment procedures for staff. We assessed recently recruited staff to ensure that the registered manager was adhering to safe recruitment practices. On day two of our inspection, we looked at the recruitment file for the new manager.

We saw that each recruitment file contained a Disclosure and Baring Service check (DBS). This is a check which employers request to be carried on potentially new staff members who will be working with vulnerable people to ensure they have no previous convictions. In addition to this, each person had two references, an application form, and a copy of their identification in their records. We did not see a medical questionnaire in one person's files. We found one person did not have notes taken at their interview, however they had a CV in place with handwritten notes on it.

We saw that there was a volunteer at the home who volunteered for an hour week. We saw a DBS had been applied for this person, which was clear, however, they did not have a personnel file in place.

We recommend that the provider reviews the processes set out in their own recruitment policy and takes action accordingly.

Due to the current situation at Barton Park and people moving out of the home, we could not speak to many visiting family members, we did speak with two visiting family members who told us they felt, "Happy and safe" with the care that their relative was receiving at Barton Park. Additionally, we spoke with two people who lived at the home who told us they liked the living at the home and liked the staff.

The home was well stocked with personal protective equipment (PPE) and there was no obvious odours or untidy communal areas. There was a cleaning schedule in place which was adhered to. The kitchen had a five-star (very good) hygiene rating. Regular checks and tests, such as gas and electricity, were completed to maintain safety in the home. We received further concerns after this inspection with regards to the hot water not working properly in the home, so we followed these concerns up and attended the home for a third day and checked this. We saw that the boiler was broken, however the part had been ordered and had arrived at the home. There was hot water available on the third floor of the home, and there was an adequate supply of hand gel in various areas around the home. We have asked to be kept updated when the boiler is fixed and the manager has agreed to keep us updated.

There was a process in place to record and analyse incidents and accidents. There had not been any reported incidents and accidents since our last inspection in April 2018.

Requires Improvement

Is the service effective?

Our findings

We checked the process in place for staff supervisions and appraisals. We were not able to locate a supervision or appraisal schedule, so we were unsure when staff last had a supervision with a manager. Supervisions are important because they are a time for reflecting on and learning from practice; personal support and professional development; in which the supervisor acts as a bridge between the individual staff member and the organisation they work for. We saw a file which contained supervisions for staff. We saw three supervisions which had taken place in 2018, the remainder had taken place in 2017, however we could not locate the documents to evidence this for all staff. We asked one staff member when their last supervision was and they could not remember. This means that regular supervision had not been taking place for staff. Similarly, for appraisals, we located some appraisals which had taken place in 2017, however we could not find evidence for all staff. The staff member we spoke with said they thought they had never had one. This means that the staff were not being suitably supervised or appraised within their role.

Additionally, there was no training or induction in place for the new manager. Also, we requested information from the manager after our inspection with regards to who was responsible for checking the health and safety of the home and what their training was. The information we were sent back evidenced that the staff member had completed an e learning course with regards to health and safety on the same day that we asked for this information. Which meant they had no previous training for this role.

This is a further breach of Regulation 18 of the Health and Social Care Act Regulated Activities Regulations 2014.

We looked at the rest of the training provided for staff. We saw that training was in date and was updated when needed. Training certificates we saw evidenced this. All care staff had an individual log in for online training and took part in practical sessions for moving and handling. The provider had an induction process in place which was aligned to the principles of the Care Certificate, the governments blueprint setting out induction standards for staff who are new to health and social care.

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 decision's 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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We saw there was some evidence of decision-making and assessment in people's care records. Additionally, some people had signed their own care plans where they had the capacity to do so. Some care plans we viewed evidenced a two-stage test for capacity, then went on to describe the level of support the person required with decision making. This is in line with good practice.

However, we saw documentation which evidenced that the service was not always working within the principles of the MCA. For example, we saw that one person had a DoLS in place which expired in 2017. When we checked to see if this person had been re-assessed as needing a DoLs or if their DoLs had been renewed as there was nothing documented for this person. We raised this with the registered manager on day one of our inspection who informed us it must not have been applied for. This person was still subject to restrictions on their liberty. This meant that the service was unlawfully restricting this person of their liberty.

We saw that another person had some conflicting information in their care records with regards to their capacity. One section of the care record read they were 'incapable of making decisions in their best interest' and stated the person had mild dementia and 'requires support to make decisions.' This had been rewritten and dated June 2018 to say they had 'mild dementia and cognitive impairment' and 'requires assistance with decision making.' There were no mental capacity assessments in relation to specific decisions, and what decisions the person could make, such as, to stay at the home.

Care files had preadmission assessments completed for two people but the section around MCA was not completed for either person. We were unsure of their decision-making ability before they came into the home compared to now.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 Regulated Activities Regulations 2014.

We checked the provision for food and drink. This was because we had received information of concern before our inspection that food stocks were running low in the home due to issues with payment to the supplier. We witnessed a delivery of fresh food and drinks on day one of our inspection and were shown order forms to evidence that food was being ordered to meet the needs of everyone at the home.

Additionally, we spoke to the chef, who assured us there was no restrictions with regards to the ordering food and drinks. The chef said, "We have a system in place to order food, and I pick up any additional fresh bits that people might want." We checked the fridges and the cupboards and saw they were well stocked. We also observed the lunchtime meal on both days of the inspection and saw that people were provided with a choice of a main course and a pudding.

When people had involvement from health and social care professionals this was mostly documented in their plans. The records were not well organised for some people, as referred to in the 'Safe' domain which meant we could not always be sure that adequate referrals had been made on people's behalf as the information was not always documented. We spoke with a visiting healthcare professional on day one of our inspection who told us that the staff had made a referral to them appropriately and had taken the right course of action to keep the person safe. The health care professional said the service had done what was expected, and they had no concerns with this.

Requires Improvement

Is the service caring?

Our findings

The last-minute change of management at the home made some people feel unsettled. One relative said, "I don't know what is going on." The decision to change the management structure between day one and day two of inspection meant that people were potentially left without any nursing provision which does not evidence a caring approach. Subsequently the issues we have highlighted in 'Safe' and 'Well-led' meant that people's health and wellbeing were not always being prioritised, which also does not evidence a caring approach.

We received positive comments with regards to the home from a visiting relative. They said that the home was, "Fabulous" and that they had, "Never any cause for concern." We spoke with one person who lived at the home who told us they liked the staff.

We spent time observing staff interactions with people who lived at the home on day two of our inspection. We observed very kind and warm relationships between the staff and the people they were supporting. There was lots of chatter and encouragement, and this evidenced that staff clearly knew people well and understood their support needs.

Staff we spoke with told us they loved the people they supported, however, they felt unsupported and 'in the dark' about the events at Barton Park. One staff member said, "It is the residents that matter and I will be here for them no matter what."

Staff demonstrated that they understood people's diverse needs and preferences. For example, we heard the chef discussing how one person like smoked salmon, while another prefers a certain brand of coffee. We saw that another person liked to have their make-up applied. We spoke to this person's relative who informed us that this was a very important part of the person's routine, as they always wore make-up. The relative said, "The staff are just so lovely the way they take the time to apply [family members] makeup."

We spoke with a healthcare professional who told us that the staff seemed caring and friendly.

People's bedrooms were personalised with their own belongings and people had photographs and personal possessions on display.

For people who had no family or friends to represent them contact details for a local advocacy service were displayed in the communal hallway. There was people accessing these services at the time of our inspection due to some people moving from Barton Park.

During the inspection we checked if confidential and sensitive information was protected in line with Data Protection. All information was safely secured at the registered location, Barton Park, in room which was kept locked when not in use. This information was kept safe and was not unnecessarily shared with others. The 'registered location' is the address which has been registered with CQC and is the address where all records and documentations should be safely stored.

Requires Improvement

Is the service responsive?

Our findings

We checked the recording and management of complaints during our inspection. We spoke with a visiting relative on day two of our inspection who informed us that they had made an official complaint to the previous registered manager six weeks prior and had not received an acknowledgment or a response to their complaint. We asked the for the complaints log, so we could track how the complaint was dealt with and check if more complaints had been received. We were not provided with a complaints log or process for this complaint when we requested it.

The complaints policy for Barton Park states that complainants should receive a written response within 28 days. This means that complaints had not been effectively dealt with, and there were no records for us to be able to check if further complaints had been received and acted upon. This meant would could not evidence that the service was acting upon and responding to complaints.

This is a breach of Regulation 16 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014

We saw that care plans were basic in their presentation; however, they did have details with regards to people's likes, dislikes and routines. Due to the care records being disorganised, it was difficult to determine from the records if people were in receipt of person centred care. Person centred means care which is based around the needs of the person and not the service. Our observations showed that staff knew people well, and they could clearly explain their routines to us. However, some recording of information was lacking in detail for some people and detailed for others. For example, one person's care plans contained information such as, how they want to dress and what name they prefer to be known as. Additionally, where they liked to eat and what activities they engaged in. For other people we had to ask staff to find out more information around people's preferences and backgrounds because there was very minimal information recorded.

We recommend that the service reviews their approach to person centred care planning and takes action accordingly.

People had information in their care plans about what action should be taken on their behalf when they passed away. Some people even had funeral plans in place. People also had DNACPR's in place which evidenced that this future planning had been discussed with them. The purpose of a DNACPR decision is to provide immediate guidance to those present (mostly healthcare professionals) on the best action to take (or not take) should the person suffer cardiac arrest or pass away. Staff were trained in end of life care and understood the sensitive nature of this.

We received mixed comments in relation to activities at the home. On day two of our inspection we saw that a singer was brought into the home to entertain people. We saw people were actively being encouraged to partake in the activity. Also, in some people's care plans there was an activities assessment which was completed by staff to show whether the person engaged and enjoyed the activity or not. However, this was not completed for everyone and some documents were blank, which meant that we could not be sure if

some people were consulted about recreational activities and how they wished to spend their time. One person we spoke with said they did not care much for the activities and liked to spend time alone. We spoke to one visiting relative who told us that their family member was often in their room and felt isolated. The local authority, who were present in the home at the time of our inspection, also informed us that this person was often left isolated and was not always encouraged to join in. We spoke with the person and they did not comment either way.

We recommend that the service reviews their process for recreational activities for people and takes action accordingly.

We saw that people's diverse needs were considered at Barton Park. For example, we spoke with the chef who explained to us that they always ensured they ordered specific food and drinks for different people because that was what they liked. The chef explained this often involved them going to different shops to ensure people got what they needed.

Inadequate

Is the service well-led?

Our findings

In February 2016 we formally notified the provider of our decision under Section 31 of the Health and Social Care Act 2008 to impose restrictive conditions on their registration. This was following criminal charges that were brought by Merseyside Police against all of the directors of Choiceclassic Ltd and others who had worked at the service. We had taken this action because we believed people may be exposed to the risk of harm unless we did so.

This case has concluded for one of the directors at Choiceclassic Ltd, who was found guilty in Liverpool Crown Court and is serving a prison sentence in respect of conspiracy to defraud, one count of fraud, three counts of theft, false accounting and transferring criminal property. The trial for the remaining directors has not concluded. We have been unable to report about this in our inspection reports up until this point, due to reporting restrictions being in place since 2014 and 2015 in respect of the criminal trials.

We have since taken further action to ensure the safety of the people who live at the home. The local commissioning authority and CCG (Clinical Commissioning Groups) have taken their own action with regard to Choiceclassic Ltd. We have kept in close contact with the local authority safeguarding and commissioning teams, and Merseyside Police before and throughout the duration of this inspection to ensure we shared concerns and always acted to keep people safe. Since this inspection has concluded, we have been in daily contact with the new manager and requested updates and information to ensure that the health and well-being of the remaining people at Barton Park is not compromised in any way.

During the time between the first arrests in 2016 and now, the Care Quality Commission has continued to monitor and inspect the service since the charges were brought against those accused. During this time there has continued to be no oversight by registered provider or on their behalf. Although the registered manager had governance systems in place, it would be expected that there should have been some level of oversight on behalf of the provider as they are precluded from entering Barton Park. The Nominated Individual (person responsible) had not been in post for a period of over two years. The Commission had not received any statutory notification as legally required that advised who was performing in this capacity in their absence. We were very concerned due to the fact that there continued to be no nominated individual at the time of this inspection and no registered manager. This meant that there was no one registered with CQC who provided oversight or was accountable for the day to day running of the home. We have requested further information and reassurance around this after this inspection concluded. However, some of our requests have not always been responded to as required or with an adequate explanation in respect of the financial viability of the business.

There was a registered manager in post on day one of inspection. However, when we returned for day two, we were made aware of operational decision that was taken to change the registered manager with a new one appointed the same day. This was the managers first day in post. We were concerned about this, as the issues around staffing had not been considered when the operational decision was taken to change the registered manager. This potentially put people at risk of harm and did not demonstrate effective leadership and governance oversight of the service.

Additionally, the new manager had no induction or shadowing opportunity and was not aware of the current situation at the home. Staff were also unaware of the changes to the management structure Staff members told us they were unsure what was happening or who they should go to. Staff we spoke with said they did not feel supported and did not know who their manager was. One staff member commented, "We are just kept completely in the dark, it's like we have to guess what is going on." This does not demonstrate effective leadership, which in turn put people's safety at high risk, due to staff not feeling supported in their roles.

We had requested information on day one of our inspection, such as information relating to supervisions, complaints, and training, and we could not be provided with some of this information when we returned on day two. The new manager tried to accommodate our requests as best as they could, however, due to it being their first day, they were unsure where some information was kept. This meant we have not been provided with such records to demonstrate the that there was good leadership and governance.

We found some audits had not been completed as required. There was a dignity audit which was due to be completed quarterly, which meant it was due at the end of April 2018. This was not completed. We saw that medication audits had not been completed since March 2018, the governance systems in place did not identify the concerns we found throughout our inspection Therefore the service was unable to demonstrate a good oversight in relation to checking service provision or the recording of information. The breach of regulation in relation to fire doors had not been adequately addressed, which demonstrated that lessons had not been learned from previous shortfalls and addressed or followed up appropriately. We have since received information that Merseyside Fire and Rescue have visited the home, and have issued their own compliance actions.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 Regulated Activities Regulations 2014.

We saw that some care plan audits and health and safety audits had been taking place regularly. We could see that when these audits did take place, they had identified some concerns, and action plans were drawn up and checked by the nurse in charge and then the previous registered manager. For example, we saw a person needed a new MUST. A Malnutrition Universal Screening Tool provides guidelines which can be used to develop a care plan using a five-step screening tool to identify people, who are malnourished, at risk of malnutrition (undernutrition), or obese. This was actioned and signed as completed.

There was some mixed feedback from staff with regards to team meetings. One staff member could not recall attending a team meeting. However, we saw minutes of a team meeting which took place in June 2018. The new manager, has also arranged a team meeting to take place in the next week to introduce themselves and provide some clarity for staff regarding the status of Barton Park.

There was a process in place for people to complete satisfaction surveys. We looked at the most recent survey and saw that no concerns had been raised by anyone living at the home.

We saw a selection of policies and procedures at out last inspection in relation to whistleblowing, health and safety, dignity and respect, diversity, and safeguarding. There had been no changes or amendments to these policies as none were required at this time. Staff we spoke with knew their roles in relation safeguarding, whistleblowing and equality and diversity, and this was reflected in their service's policies and procedures.

From April 2015 it is a legal requirement for providers to display their CQC (Care Quality Commission) rating.

'The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided'. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate. The rating from the previous inspection for Barton Park was displayed in the main part of the building, and the registered provider's webpage.

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 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	People were not receiving care in accordance with the principles of the MCA. Some information around decision making was conflicting and not specific.

The enforcement action we took:

We applied to magistrates court to urgently cancel the provider's registration under section 30 of the Health and Social Care Act. The application was granted by the court and issued to the provider on 3 August 2018.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Fire doors were not being used appropriately which put people at risk of harm.

The enforcement action we took:

We applied to magistrates court to urgently cancel the provider's registration under section 30 of the Health and Social Care Act. The application was granted by the court and issued to the provider on 3 August 2018.

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 potential abuse and exploitation due to some next of kin information not being updated and corrected.

The enforcement action we took:

We applied to magistrates court to urgently cancel the provider's registration under section 30 of the Health and Social Care Act. The application was granted by the court and issued to the provider on 3 August 2018.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 16 HSCA RA Regulations 2014 Receiving

personal care Treatment of disease, disorder or injury	and acting on complaints Complaints were not being recorded or responded to in line with the registered providers complaints policy.

The enforcement action we took:

We applied to magistrates court to urgently cancel the provider's registration under section 30 of the Health and Social Care Act. The application was granted by the court and issued to the provider on 3 August 2018.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Oversight was not being managed appropriately as there was no registered persons who were accountable for the day to running of the home. Auditing and record keeping was poor, and there were numerous gaps and inadequately recorded information regarding people's care needs.

The enforcement action we took:

We applied to magistrates court to urgently cancel the provider's registration under section 30 of the Health and Social Care Act. The application was granted by the court and issued to the provider on 3 August 2018.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was not adequate nursing provision on day two of our inspection due to the registered manager being dismissed from post.

The enforcement action we took:

We applied to magistrates court to urgently cancel the provider's registration under section 30 of the Health and Social Care Act. The application was granted by the court and issued to the provider on 3 August 2018.