Barrels UK Care Ltd

The Firs Residential Care Home

Inspection report

Tower Farm
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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

About the service: The Firs Residential Care Home is a residential care home that was providing personal and nursing care to 26 people aged 65 and over at the time of the inspection.

People's experience of using this service:
Risks to people were not managed safely. People were at risk of choking due to swallowing difficulties and this was increased because staff did not always follow guidance about food and drink preparation. People had lost weight but not enough action was taken to reduce the risk of this continuing. Staff did not know how to support people with their health conditions, such as diabetes, which put them at risk if these worsened. People were at risk from a lack of staff understanding about moving and handling equipment.

Fire evacuation information was incorrect and had not been updated to include all of the people living at the home. The safety and effectiveness of giving medicines covertly had not always been considered as advice or alternative medicines had not been sought. Safeguarding referrals were not made to the local authority safeguarding team and the manager did not recognise when this was required.

There was a lack of managerial oversight at the home, which lead to low staff morale and a high turnover of staff. The provider's monitoring process did not look effectively at systems throughout the home. Where issues were identified, there was a lack of action to address them and these continued. There were not enough staff available to make sure people received care in a timely way. People had to wait for care, meals and to go to the toilet. Staff recruitment checks were not always fully obtained before new staff started working at the home.

Lessons were not learned about accidents and incidents and it took time to implement actions to reduce these. Medicines were stored safely, and records were completed correctly. Regular cleaning made sure that infection control was maintained and action was taken to address issues.

People were cared for by staff who had received some training but did not have all the skills or support to carry out their roles. People received a choice of meals, which they liked, and staff supported them to eat and drink. People were referred to health care professionals as needed although staff did not always follow the advice professionals gave them. Adaptations to the environment were made to ensure people were safe and able to move around their home as independently as possible. Staff members understood and complied with the principles of the Mental Capacity Act 2005 (MCA). People were supported to have choice and control of their lives. Staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Staff were caring, kind and treated people with respect. People were listened to and were involved in their care and what they did on a day to day basis. People's right to privacy was maintained by the actions and care given by staff members.

People's personal and health care needs were met and people were happy with the care they received. Some care plans were written in detail to provide guidance to staff Other care plans were not available and staff did not always have appropriate guidance to care for people. There were activities for people to do and take part in and they enjoyed these when they were available. However, people told us they had little to do when the staff member responsible for these was not working. A complaints system was in place but complaints had not been investigated and responded to when they were first made. Staff had some guidance and support about people's end of life wishes, although information in care records was limited.

We found several breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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 service met the characteristics of Inadequate in two areas and Requires Improvement in three areas; more information is in the full report.
Rating at last inspection: This was the first inspection for this service.

Why we inspected: We brought this inspection forward due to information of risk and concern received from the local authority.

Enforcement: Action we told provider to take (refer to end of full report)

Follow up: The service has been placed into Special Measures. Services in special measures will be kept under review and will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures which may lead to begin the process of preventing the provider from operating this service. We will continue to monitor all information we receive about the service and schedule the next inspection within six months of publication of this report.

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.

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our Responsive findings below.

Is the service well-led?

Inadequate

The service was not always well led.

Details are in our Well-led findings below.

The Firs Residential 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by information of concern we received from the local authority and complaints we received. The information shared with CQC indicated potential concerns about the management of risk of falls.

Inspection team:
This inspection was carried out by two inspectors and an inspection manager on one day, and two inspectors and an expert by experience (ExE) on a second day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type:
The Firs Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulated both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. This means that the provider is solely 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 our inspection we looked at all the information we held about the service including notifications. A notification is information about events that the registered persons are required, by law, to tell us about. We used this information to assist with planning the inspection.

We asked for feedback from the commissioners of people's care, representatives from the local authority and Healthwatch Cambridge.

During our inspection visits on 23 January and 6 February 2019, we spoke with seven people and three visitors. We also spoke with the provider's representative (referred to in this report as 'the provider'), the deputy manager, four care staff, the activities coordinator, the chef and a member of the housekeeping staff. We looked at five people's care records. We also looked at other files in relation to the management of the service. These included three staff recruitment and training records, complaints and compliments records, and records relating to the systems for monitoring the quality of the service.

Inadequate

Is the service safe?

Our findings

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

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management

- Risks to people were not always assessed, monitored or mitigated effectively to ensure people were safe. There were no systems in place to ensure the safety of people who had swallowing difficulties. Staff did not always give food and drink of the correct prescribed consistency people at risk of choking because they did not have the correct or current information and guidance to follow. Staff had not received any training to help them understand the risks or know what action to take if a person began to choke.
- Staff did not assess the risk of people losing weight. Although people's weights were being measured, where people were losing weight appropriate action was not taken to reduce the weight loss or reverse it. No action had been taken for people who had lost significant weight loss in a short period of time such as referral to GP and/or dietician.
- For people with diabetes, there was no relevant care planning or guidance for staff to support them properly and safely if they had a high or low blood sugar level. Staff had not received relevant training and were unaware of the difference between too high or too low blood sugar level and the appropriate action to take if a person with diabetes became unwell.
- Moving and handling practices were not managed safely and people were at risk of potential harm due to the lack of clear guidance and staff knowledge.
- Emergency evacuation processes did not provide enough guidance to support people to leave in the event of a fire. The fire risk assessment and evacuation plan were not up to date and contained incorrect information about which person was in which room. Not all staff had received fire safety training, which coupled with a lack of written guidance, meant people were at risk of harm if there was a fire.
- The home did not have any sluice facilities to empty, wash and disinfect commodes and staff used personal washing facilities for this purpose. This is poor practice and places people at an increased risk of cross infection.
- Staff were crushing medicines to give covertly [hidden] to a person without checking with a pharmacist that it was safe to do so. Medicines taken out of their original form may not be as effective or may cause harm.

Systems and processes to safeguard people from the risk of abuse

- The provider did not have robust safeguarding systems in place for management and staff to follow. Where a concern had been raised it had not been dealt with properly. It was not brought to the attention of the local authority safeguarding team who provide oversight in these matters to ensure safeguarding responsibilities are carried out properly and people are protected from harm.
- Staff were not trained and developed to fully understand their role and responsibilities in safeguarding people or how to properly apply appropriate policies and procedures if circumstances required it. Staff

members told us they would investigate and take statements from people or other staff, which is not in line with local authority safeguarding protocol and could jeopardise any potential criminal investigation.

Staffing and recruitment

● There were not always enough trained and competent staff available to meet the needs of people in a safe way.

● The provider did not have any arrangements in place to make sure there were enough skilled staff deployed across the service to meet people's needs and keep them safe, particularly at key times. One person told us, "When I want to go to the toilet I always have to wait for someone to come and sometimes it's too late." Due to the shortage of staffing numbers staff were unable to get some people washed and dressed until late morning and people did not receive their breakfast until they were up. One person did not receive their breakfast in the dining room until 11.30am; lunch was served at 12.30pm. This did not give reasonable periods of time between meals for people to eat sufficient food and drink regularly.

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

● Recruitment practices were not safe. Pre-employment checks were not completed before new staff started working at the home which would help to make sure potential new staff were suitable to work with people who are vulnerable. Employment histories had not been explored for five staff and appropriate references had not been obtained for three staff. A Disclosure and Barring (DBS) check was not obtained before one new staff member started working at the service. DBS helps employers make safer recruitment decisions and helps to prevent unsuitable people from being employed.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Staff administered medicines safely and maintained records to show this. There were instructions for giving most medicines that needed to be taken in a specific way. However, times for giving antibiotics were not always equally spaced throughout the day to ensure a constant level of medicine in the body is maintained to fight infection.

● Medicines were stored securely, although this had not been the case for the month prior to our visit when medicine trollies were not secured to the wall.

Preventing and controlling infection

● There were no offensive odours and the home was mostly clean during our visit. Dedicated staff were available to make sure cleaning was carried out each day. However, we found that curtains around hand washing sinks were not always clean where they had been attached to the sink.

Learning lessons when things go wrong

● There were no arrangements in place for reviewing and investigating incidents and events when things went wrong which meant themes were not identified and lessons were not learned. Following two separate errors made in administering medicines no action was taken to review circumstances for error and prevent re-occurrence.

● Staff recorded accidents and incidents such as falls and immediate action was taken to attend to the individual. However, where there were ongoing issues, such as repeated falls there was no analysis carried out to identify any trends and themes that could be addressed to reduce re-occurrence.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

RI:□The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Staff support: induction, training, skills and experience

● Staff did not receive adequate training or support to enable them to carry out their duties effectively and safely.

Induction and training was delivered via short guidance DVDs followed with a short questionnaire. This method of delivery provided an introduction and brief overview to subject areas but did not support staff in developing their knowledge and skills. One staff member had watched DVDs in nine subjects over one day. A staff member commented about this type of training, "If I have a question, how can I ask the TV?" Staff confirmed that they had not received training in practical aspects of fire safety, evacuation or moving and handling.

● Staff were not supported to commence the Care Certificate, a nationally recognised training that identifies a set of standards and skills that care staff should adhere to and includes assessments of competency.

● Staff had not received training in relation to people's individual needs associated with long-term conditions such as dementia, Dysphagia, Parkinson's Disease, Diabetes or End of life care to enable them to deliver safe and appropriate care.

● There was no monitoring process of the standard of care being delivered by staff and to also identify any training needs.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

●Staff had a limited understanding of how dementia affected people in their day to day living. There was no plan about how the service kept up to date with developments in this area to ensure the care given was right and reflected best practice.

Supporting people to eat and drink enough to maintain a balanced diet

● People told us they liked the meals they received. One person said, "The food is good; there's a choice and the cook is good." Staff asked people what they would like to eat each day and returned if people were unable to make an immediate decision. Although staff showed people and asked which sandwiches they would like for tea, people could not see what their lunch options were. This occasionally made choosing difficult for people when they could not visualise what meals were available.

● People were able to eat their meals where they wanted and staff sat with those who needed support and encouragement to eat. If people were hungry between meals they were offered something to eat, such as a

banana. One person said, "I can get a bacon sandwich when I want."
● Mealtime in the dining area was a social occasion with people able to choose where they sat and take part in conversations around the tables. They were able to eat at their own pace and generally both courses and meals were appropriately spaced apart.

Staff working with other agencies to provide consistent, effective, timely care
● The provider did not have a system in place to ensure staff work together to ensure people received co-ordinated, person-centred care and support when they move between services. One staff member told us that things at the home were so disorganised that staff did not always know what advice hospital staff or the person's GP had given. One person had returned from hospital with a specific diet recommended, however staff were not aware for two days.

Supporting people to live healthier lives, access healthcare services and support
● People were referred to health care professionals for advice and treatment, for example to Speech and Language Therapists or the falls team. Advice and recommendations were not always followed by staff, particularly in relation to the provision of varied textured foods and thickened fluids. Staff had not supported people effectively to enable them to understand why they needed food and drink in this way.

Adapting service, design, decoration to meet people's needs
● Adaptations had been made to ensure people were able to move around the home safely. A hand rail was in place along one side of each corridor; this was painted in a contrasting colour to the walls so that it stood out. Equipment was in place in toilets and bathrooms to allow people to safely use these areas.
● Wall boxes filled with personal photographs and memorabilia helped people to recognise and identify their bedroom. Signs for communal areas, such as toilets, dining and lounge areas were sign posted with pictures, words and arrows pointing the way. There were 'fiddle' boards along one corridor, which provided people with tactile sensory stimulation as they walked along this area. These provided some support so that people living with dementia could find their way around. The corridor's had no natural light and the lighting provided during the day was dim. This did not provide a safe environment for people with partial sight or visual conditions caused through old age and frailty.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
● Staff members had received training in the MCA and DoLS in the month before this inspection. They had an understanding of the MCA and encouraged people to make decisions for themselves.
● Where people did not have capacity, decisions were made in their best interests and involved relatives and health professionals where appropriate. However, some decisions, such as DNACPR (do not resuscitate) were not always reviewed and updated when people's needs and capacity changed.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

RI:□People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported; equality and diversity

● People and their relatives said that staff were kind and caring. One person said, "They treat me well. I'm very comfortable here." A visitor told us, "The staff are all very friendly and kind."

● Staff spoke with people politely and addressed people by their names, they knocked on people's doors before entering their rooms.

● Staff knew people well, how to encourage them to take part in events during the day and when to sit with people if they were distressed or upset.

However, the provider had not encouraged a culture that supported staff and promoted a service centred on the people that used it.

Supporting people to express their views and be involved in making decisions about their care

● People were able to make choices about what they wanted to do and where they wanted to sit, and staff respected their decisions. A visitor told us, "They're really good and patient with [family member]," and went on to explain how staff supported the person with their choices at mealtimes and during personal care.

Respecting and promoting people's privacy, dignity and independence

● People told us that staff treated them with respect. We observed a staff member spend time with a person who was distressed, providing them with reassurance and support which helped them to settle in a dignified way.

● Care records contained guidance for staff about what people could do for themselves and what they needed support with. For example, the areas of their body that the person could wash themselves.

● Some practices did not promote dignity or wellbeing such as doubling up on continence pads. There were notices around the home reminding staff not to do this and it was raised with staff at a staff meeting. This practice increases the risk of skin breakdown as well as being undignified, uncomfortable and unclean.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

RI:□People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

● People and their relatives were positive about the care they received. One person told us, "They care for me very well."

● Care plans were not consistently written in a way that promoted personalised care. Some described people's strengths and abilities to enable staff to support them to maintain their independence. Others contained little information about how dementia affected the individual in their day to day living and the type and level of support they needed from staff to ensure the care given was appropriate and consistent.

● There were no care plans to guide staff on people's health conditions and staff did not understand what they were required to do if health conditions deteriorated.

● One staff member's role was to organise things for people to do each day and while this staff member was available people were occupied with a musical session. The people who participated in this clearly enjoyed the event and the staff member also supported people individually in their rooms. However, when this staff member was not available, care staff were not able to continue this interaction with people. This left them with little to do. One person told us, "I come down and sit in the lounge every day. I enjoyed the singalong this morning, but there's nothing much to do." While another person commented, "There's nothing to do, but sit here. I wish there was more entertainment like music and singing."

Improving care quality in response to complaints or concerns

● There was a system in place to deal with any concerns or complaints. However, the manager had not dealt with these when they had been made.

● Complaints had since been found by other staff after people's relatives contacted the local authority with their concerns. Investigations and actions were taken as a result, although not within an appropriate timeframe.

End of life care and support

● Staff had not received training in end of life care.

● Other guidance was available for staff in the form of an end of life policy and the support of the district nurses.

● Care plans were in place but these contained basic information. For those people who were nearing the end of their life, there was no personalised information to show how they'd like to be cared for at this time.

Inadequate

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

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

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

- The service did not have a registered manager. Relevant legal requirements such as the submission of notifications were not met. The Commission had not been notified of specific events that had occurred such as a safeguarding concern or incident where a person had sustained an injury which the provider is legally required to do.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009

- The provider did not have oversight of the home and staff felt there was a lack of leadership and morale was low. They told us there had been a large turnover of staff and many experienced staff had left since the appointment of the new manager. One newer member of staff said that they did not intend to stay at the home as there appeared to be no direction. Other staff said that they did not feel supported by management, the manager had been unapproachable and one staff member told us, "I don't know if I'm allowed in the office." None of the staff we spoke with said they would wish for a relative to live at the home.
- One person's visitor told us that staff always kept them informed if anything happened to their relative.
- At the time of our inspection the manager was absent from work and the home was being managed by a recently promoted deputy manager. They did not have the training or experience to carry out the management role and they were not being sufficiently supported by the provider, or others.

Continuous learning and improving care

- There were limited processes in place to effectively monitor and continually assess the quality of the service and if it was operating safely, such as fire safety and infection control.
- The provider and management had failed to carry out audits on a regular basis and therefore had not identified where lapses had occurred, such as poor recruitment practices and assessment and management of risk. Where audits had been completed and shortfalls identified, action had not been taken to address them. For example, an issue identified in the December 2018 medicines audit was not addressed until we raised it on the first day of our visit.
- Analysis of audits, complaints, or accident and incident records had not been carried out, which meant they could not see where improvement was needed in order to minimise risks of similar incidents happening again. This did not support continuous improvement or learning.

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

2014.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

● There were insufficient numbers of skilled, trained and competent staff to promote a service that was person centred. Care and support was not in line with best practice and staff training and development was poor.

● The provider did not keep the day to day culture of the home under review. Although the provider's representative visited the home, they did not spend time with people or staff and consequently did not understand the challenges, concerns or risks.

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

● There had been one meeting with people and relatives when the provider and manager first took over the home. Their views of the home, how it was run and the service provided were not sought after this meeting.

● Staff attended meetings to cascade information about the way they worked, although this did not provide them with an opportunity to share their concerns.

Working in partnership with others

● People did not always receive joined up care. This was because staff did not always follow guidance or recommendations from health care professionals. Nor did they have a good understanding of their responsibilities following on from a professionals involvement.

● The provider had only established a working relationship with other agencies, such as the local authority safeguarding team, following concerns raised by people's relatives. This meant that the provider and manager had not worked in partnership with other organisations for the benefit of people living at the home.

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 18 Registration Regulations 2009 Notifications of other incidents How the regulation was not being met: Notifications of possible abuse and serious injury were not submitted as required by the regulations. Regulation 18 (2) (a) (ii), (e).

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 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people who use services were assessed or adequately mitigated to reduce that risk.

The enforcement action we took:

Urgent notice of decision to stop admissions and impose conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was inadequate management and oversight of the home to ensure people were not place at risk.

The enforcement action we took:

Urgent notice of decision to stop admissions and impose conditions.