Care and Residential Homes Ltd

Barham House

Inspection report

Barham House Nursing Home
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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 16 and 17 January 2017 and was unannounced.

Barham House is registered to provide nursing and personal care for up to 23 people .There were 22 people using the service during our inspection; who were living with a range of health and support needs. These included; diabetes, catheter care, dementia; and people who needed support to be mobile.

Barham House is a detached house situated in the village of Barham near Canterbury, Kent. The service had a very large communal lounge available with armchairs and a TV for people and a separate, quieter lounge, where people could entertain their visitors. There was a secure enclosed garden to the rear of the premises, with far-reaching views across open countryside.

A registered manager was in post. A registered manager is a person who has registered with the care Quality Commission to manage the service. 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.

Barham House nursing home was last inspected in September 2014. At that inspection it was found to be compliant with Regulations.

At this inspection we found that the service required improvement in all areas. Although we saw some features of good care, there were other aspects which fell below acceptable standards. We received mixed feedback from people and relatives about their experiences of the service.

Some risks to people's safety and well-being had not been appropriately reduced. This included those associated with people who were unable to use call bells, people who needed support to reposition themselves to prevent pressure wounds and risks around eating and drinking. Environmental, fire and maintenance risks had however been properly addressed.

Medicines had not always been stored securely, and auditing had failed to pick up on missed staff signatures to show that people had received their medicines. Medicines were well-organised in trolleys and regular recordings had been made of the temperature of the medicines room and fridge.

Some areas of the service were not appropriately hygienic; although a planned deep clean took place following the first day of our inspection.

Recruitment processes were robust but there were not always enough staff on duty to meet people's needs. Staff received regular training and supervision but this had not highlighted some shortfalls in staff knowledge or practice.

Safeguarding processes were understood by staff. Accidents and incidents were properly recorded but actions taken to prevent recurrences were not always documented or effective.

People had plentiful, nutritious meals but did not always receive the support they needed to eat them. Records of what people ate and drank were not always accurate and posed the risk that poor intake would be overlooked. People had input from the GP, tissue viability nurse (TVN), podiatrist, dieticians and other professionals.

Staff were knowledgeable about the Mental Capacity Act (MCA) 2005 and worked within its principles. 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 are called the Deprivation of Liberty Safeguards (DoLS). The registered manager understood their responsibilities around (DoLs) and had made a number of applications to the proper authority.

Staff were mostly caring and kind to people but the attitudes of some staff were disrespectful at times. There were limited activities for people day to day, although those people who were able went on occasional outings.

Complaints were managed appropriately by the registered manager and people and relatives knew how to raise concerns if necessary. People and relatives feedback was sought through a comments book and survey; although responses had been few.

There had been insufficient management oversight of the service and audits had not always been effective in identifying shortfalls in quality and safety.

We recommend that the provider sources suitable picture menus to provide the appropriate support for people living with dementia or other memory impairment.

We recommend that the provider updates diabetic care plans with information about individual blood sugar level parameters.

We recommend that the provider sources reputable end of life care training for staff and updates care plans with greater detail about people's choices and decisions.

We found a number of breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back 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?

Requires Improvement

The service was not consistently safe.

Individual risks to people had been assessed, but actions to minimise them did not always happen.

Medicines were not managed in a way which made them consistently safe.

Standards of cleanliness were not sufficient to prevent the risk of infection.

There were not always enough staff deployed to keep people safe.

Recruitment processes were robust and helped ensure the suitability of applicants.

Environment and equipment safety checks had been regularly undertaken.

Staff were knowledgeable about abuse and knew how to report it.

Is the service effective?

Requires Improvement

The service was not always effective.

Records of food intake were sometimes inaccurate or incomplete and could be misleading. People did not always receive the support they needed to eat and drink.

Staff training and supervision had not been effective in highlighting some shortfalls in knowledge.

People's health was monitored and referrals were made for professional input. This did not always happen promptly however.

Staff understood the principles of the mental capacity Act (MCA) 2005 and acted accordingly. Deprivation of Liberty safeguards (DoLS) applications had been made when necessary.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Most staff delivered support with consideration and kindness but others were brusquer.
Information about people's end of life care wishes was limited and few staff had received training in this area.

People told us their dignity was respected.

Staff encouraged people to be independent when they were able.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was little day to day activity for people to enjoy.

Care plans were generally person-centred and documented individual needs; but these were not always followed through in practice.

Staff knew people very well and people had been involved in their care planning where possible.

People and relatives were given the opportunity to make complaints or raise concerns.

Is the service well-led?

Inadequate

The service was not consistently well-led.

There had not been sufficient management oversight of the service; leading to a decline in standards.

A poor culture had developed amongst some staff which led to inappropriate attitudes going unchallenged.

Feedback had been sought from people and relatives but more could have been done in this area.

The registered manager was approachable and visible in the service and staff said they could speak to them with concerns.

Barham House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 16 and 17 January 2017 and was unannounced. One inspector, a specialist nurse advisor and an expert by experience carried out the inspection. The specialist nurse advisor had nursed older people and the expert by experience had personal experience of caring for older people living with dementia.

Before our inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the home, including previous inspection reports. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at any safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We met with eighteen of the people who lived at Barham House. Not everyone was able to verbally share with us their experiences of life in the service. We therefore spent time observing their support. We spoke with four people's relatives. We inspected the home, including the bathrooms and some people's bedrooms. We spoke with two nurses, five care workers, the cook and the registered manager.

We 'pathway tracked' seven of the people living at the service. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the home where possible and made observations of the support they were given. This allowed us to capture information about a sample of people receiving care.

During the inspection we reviewed other records. These included three staff training and supervision

records, three staff recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

Most people we spoke to were unable to tell us about their experiences of living at Barham House. This was because they were living with dementia or other conditions which limited their ability to fully engage with us. However, those people who could speak with us gave mainly positive feedback about their care. One person told us "I'm as safe as you like, tucked up in bed here with my bell next to me. I just need to press it and someone comes straight away". Another person said "I know help is close by any time day or night". A further person told us "Knowing there's someone a moment away from my door makes me feels safe".

Our findings, however, did not always agree with the comments made by some people; and we received mixed feedback from the relatives we spoke with during and after the inspection. We found that people who were less able to express themselves and their needs did not receive consistently safe care.

Assessments had been made about individual risks to people, with clear directions about how these could be minimised. However, actions to reduce risks were not always carried out by staff, leaving people exposed to potential harm. For example, many people were unable to use call bells to summon staff help when they needed it. The risk to some people was increased because their bedrooms were in small corridors off a main landing upstairs. This meant staff and visitors would not be routinely walking past people's rooms to hear or see if they needed support. Hourly checks had been assessed by the registered manager as necessary to keep these people safe, and although this generally did happen, records showed that there were sometimes gaps of longer than an hour between these checks. Two people had several gaps of two hours between checks and one record showed a five hour gap. This placed people at potential risk and we observed one person in their room reaching down to pick up a dropped item and almost overbalancing in their chair until we intervened. Another person was seen with their leg hanging over the side of their raised bed side and we heard people calling out for staff at times when there were none nearby.

Other people were at risk from skin breakdowns and had been assessed as needing regular repositioning to prevent pressure being placed on one side of their body for too long; which can cause sores to develop. One person's care plan said they were prone to pressure ulcers and should be supported to turn onto their side every three hours during the night. The registered manager told us that records of repositioning would be made on the same document that recorded hourly room checks. However, there was no record that turns had happened. Another person who had a history of pressure wounds was supposed to be repositioned every two to three hours. Records showed they had been supported to turn only twice on one day and there were gaps of five and seven hours between turns on another day. This person had a recent skin wound which had healed, but the lack of a robust turning regime was not helpful in preventing further breakdowns.

Known risks had not been mitigated which is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing levels did not consistently meet people's needs. Most people were supported by two staff with their care and some people were nursed in bed. People had conditions such as dementia, stroke, arthritis,

Parkinson's, MS and diabetes. Many people had continence needs. The registered manager told us that there was one nurse and five care staff on duty in the mornings and one nurse and three care staff in the afternoons until 6pm. A further care staff member came on duty between 6pm and 10pm and there was one nurse and one care staff working the shift between 8pm and 7am. On the first day of our inspection there were only four care staff working with the nurse in the morning because one staff member had called in sick. The registered manager was unable to find cover for them, so the shift ran short staffed. We checked rotas with the registered manager and found that there had been four other shifts that had run with one care staff short since the beginning of January 2017.

The registered manager used a dependency tool to work out how many staff were needed per shift, based on people's needs. However, the tool did not take account of the layout of the building; with some people being quite isolated upstairs; which meant that people who could not use call bells needed to be checked every hour during the day and night. People had limited independence due to their impaired mobility and so required staff support with most tasks.

Our observations showed that there were times during both days of our inspection when some people's needs were not appropriately met to keep them safe. For example; people were left alone in the lounge for long periods, without any staff interaction or attention. One person dropped a knife at lunchtime and was trying to pick this up from the floor between armchairs. They were slipping down while doing so until we intervened. There were no staff in the vicinity. We read incident reports which showed that two people had slipped from their chairs in the lounge on four separate occasions. Reports documented the events in detail but there was inconsistent information about preventative actions taken. Another person seated there had a severe cough and was struggling to catch their breath but there were no staff there to see this and assist and reassure the person. We spoke with the registered manager about this but they confirmed that they had not allocated a staff member to supervise people while in the lounge. They told us that their office was next to the lounge and they would hear if anyone was in difficulty there. The positioning of the office meant it was not possible to see people in the lounge from it and the registered manager was not always in it in any event.

Staff told us that people sometimes had to wait longer than usual to receive attention when the shifts were short staffed. We observed one staff member leaving the medicines round to respond to a call bell which had been sounding for several minutes. There were no other staff nearby to do so and interrupting the medicines round can cause mistakes to happen. Staff also said that an extra member of care staff would make the afternoon shifts run better. This was because there were three care staff working afternoons, and with most people needing two staff to support them, there was only one pair of care staff available at any one time. One relative told us "Staff do their best, they're very busy and sometimes they run around like headless chickens if they're short". Another said"Staffing is lower at weekends. I get mixed impressions; sometimes staff respond very well to call bells and other times waits can be very long".

The failure to ensure sufficient staff are deployed to meet people's needs is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us that they sometimes used agency staff or other permanent staff to cover shifts, but that this was not always possible at short notice.

Medicines were not always stored securely. The medicines trolley was left wide open and unattended twice during the inspection, despite us pointing out the issue to staff. Thickening granules, which are known to be dangerous if ingested dry, were left out in people's bedrooms. Although no people were independently mobile, which reduced the risk of them being able to access the medicines trolley or thickener, there were

visitors to the home who might do so.

Medicines records (MAR) had been neatly completed but we found several gaps on them where staff had failed to sign to confirm that people had received their medicines. Daily medicines audits had not picked up these gaps and so it was possible that people had not received their medicines as prescribed to them. Pain relieving patches are supposed to be applied to a different place on the skin at each application, to prevent irritation. Charts about this had been inconsistently completed, so there was not always a record of where they had been placed.

The failure to store and record medicines properly is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Temperature records of the medicines room and fridge were consistently completed and within acceptable ranges. Medicines about which there are special legal requirements were stored and monitored appropriately. Medicines trollies were well-organised and liquid medicines had been dated to show when they were first opened, so that they could be disposed of within the proper timescales. Staff stayed with people while they took their medicines to ensure that they had been swallowed and offered people pain relief where this was prescribed for them.

On the first day of our inspection the service was not clean to an acceptable standard. Carpets were stained and had food and other debris on them, used latex gloves and aprons were seen in open waste bins and faecal matter was spattered over wall tiles and the flushing bowl in the sluice room. Some armchairs in the lounge were stained and in poor condition and there was a strong odour of urine in some bedrooms. A relative told us "My relative's room often smells of urine or smells stale and unclean and is generally left cluttered". Older people and those requiring nursing care are more prone to infection and good hygiene and cleanliness are important to ensure their well-being.

A deep clean happened on the evening of the first day of our inspection, which the registered manager told us had been pre-booked; and on the second day, some areas of the service were more hygienic. However some odours lingered and the armchairs remained soiled. The laundry room had painted brick walls which were chipped and the floor there was uneven and worn in places. These surfaces were not easily cleanable and posed a risk that they could become contaminated through dirty and soiled items. The registered manager told us that there were plans to relocate the laundry but these had not been firmed up at the time of the inspection.

Some hoist slings were shared between people; which can be an infection risk. The registered manager told us that the slings were regularly laundered by night staff, but the records we were given did not confirm how often the slings had actually been washed. Domestic staff worked to cleaning schedules but these were not sufficiently detailed to ensure that all tasks were completed thoroughly. The registered manager told us that they were planning to meet with domestic staff as she had also picked up that cleaning was not adequate following an audit on 30 December 2016.

The lack of consistent cleanliness is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were observed using plastic aprons and latex gloves when they provided personal care to people. Antibacterial hand gel was available around the service. Aprons were changed if care staff entered the kitchen to prevent any cross-contamination and there was a system in the laundry to stop clean items coming into contact with dirty or soiled clothes and bedding.

Environmental safety had been assessed and managed by the provider. The service employed a maintenance person who kept records of any running repairs they were asked to carry out, together with the date they were completed. There was also a maintenance action plan in place for more involved works and this had been updated with progress on those jobs. Safety checks had been regularly undertaken on gas and electrical supplies, appliances and equipment. Hoists, baths, the sluice and the passenger lift had been routinely serviced and water temperatures had been checked to ensure they were safe for people. The premises were secure and all visitors had to be escorted by staff from the outer reception area into the service. Visitors were asked to sign in for both fire safety reasons and to have a record of those who had been into the service.

All staff had received fire safety training and refreshers. We read records to show regular testing of the fire alarm, and the registered manager took time to point out fire exits to the inspection team on arrival. These were clearly signposted and unobstructed and emergency lighting and fire extinguishers had all been frequently checked. Annual fire reviews were documented and had been carried out by an external contractor with expert knowledge. People had individual emergency evacuation plans in place to show the equipment and staff needed to support them in the event that they needed to leave the building.

The provider had a robust recruitment system in place to make sure that only suitable applicants were recruited to work with people. Application forms documented complete work histories, with any gaps explained. Interview records showed that the registered manager had asked questions designed to measure applicants' suitability for the post and to explore their reasons for wishing to work in the service. Police checks had been correctly undertaken and documented so that the provider could make an informed decision about which applicants were safe to employ. Identity documents had been seen and copied to evidence the right to work in the UK and each staff member had a current photo of them on file. References had been sought and received before any job offer was made.

Staff had received training about protecting people from abuse. Those we spoke with were confident in their knowledge of the forms abuse can take and said they would not hesitate to raise concerns with the registered manager if they ever suspected that a person was a victim. Staff knew that they could 'Whistle blow' by contacting external organisations such as the CQC if they had reason to be concerned about practices in the service. The registered manager had raised alerts with the local safeguarding authority when necessary, so that events could be considered for independent investigation by them.

Requires Improvement

Is the service effective?

Our findings

People who were able to speak with us said "Everyone [staff] knows what's what around here. The girls know what they're doing and what is required for me" and "There is a trained nurse and I believe the carers get training too as they're all very knowledgeable". A relative said "[Person's name] is supported excellently, with skill, care and dignity".

Some people needed support with eating and drinking. One person's care plan documented that they should have a plate guard and non-slip placemat to assist them. They also required encouragement and prompting to ensure they ate enough. On the first day of our inspection this person was not provided with either the plate guard or non-slip mat. Food was placed in front of them with minimal interaction from staff and they were offered no support or encouragement. Cook told us that this person needed their meat to be cut up for them, but they were given stewed beef which contained large pieces. Staff did not cut the meat up and this person struggled to eat anything other than the semolina pudding. We brought this to the attention of the registered manager but on day two of the inspection, this person's lunch was again served without a plate guard or non-slip mat; until the registered manager intervened. This person's food intake was being recorded on a chart because they had been assessed as at risk of weight loss. We checked the chart after lunch and saw that staff had recorded that this person had refused to eat any of their meal. This was incorrect as we had observed them eating semolina and some meat.

There were no staff in the lounge while people ate their lunches. People were served dessert at the same time as their main meal. Some people were living with dementia or memory loss and we observed people eating their dessert before attempting any of the main meal. This meant people were filling themselves up with pudding rather than eating the more nutritionally-balanced lunch.

There were further inaccuracies in the recording of some people's intake. In the morning we saw that another person had eaten about half a bowl of porridge and half a slice of toast before staff removed their tray. However, their food chart documented that they had eaten a big bowl of porridge and a full slice of toast. This person had lost just over 3kgs since November 2016 and they had been referred to and seen by a dietician. It was important that staff maintained accurate details of this person's intake, so that their weight loss could be monitored and further professional input sought if necessary.

Some people had been assessed by a dietician as needing meal supplements. We checked food and fluid charts for people who had been prescribed these but found that they were rarely documented. For example; we saw an unopened and full bottle of food supplement in one person's bedroom on both days of our inspection. This person was supposed to have the supplement twice daily. The food and fluid charts for this person did not include any information about how much of the supplement drinks were taken on the five days prior to our inspection.

The registered manager told us that food supplements were given out by nursing staff and recorded on the MAR. We checked the MAR for the person who had the bottle of unopened supplement drink in their room. The MAR was signed off to say it had been given on both days, but there was no further record to show when

and how much had been drunk. This meant it was not possible to properly and accurately monitor people's intake to ensure they were eating and drinking enough to remain well.

Some people needed to drink plenty of fluid as they were at risk of urine and kidney infections. One person who had been assessed like this had charts which showed 600mls drunk on one day and 150mls and only sips of fluid on others. The registered manager told us that this must be a recording error but they conceded that there was no evidence to show that this person had received adequate amounts to drink. People did have drinks in their bedrooms or on their tables in the lounge. However, these were not always within people's reach when they were in bed, and some people needed support from staff to take fluids.

The failure to appropriately meet people's eating and drinking needs is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meals appeared appetising, nutritious and plentiful. People were given a choice of main meals and could select something different if they did not like what was on the menu. Most people we spoke with thought the meals were of good quality and that people enjoyed them. One person said "Very good meals, exceptional, I can't complain one little bit". Another person told us "Marvellous meals, I look forward to them" and a relative remarked "Food is lovingly prepared and served". Another relative remarked that supper was "Hit and miss. A lot of cold sausage rolls that people don't eat. Sandwiches are better and are really rather good". There were no picture menus in use to help people living with dementia to make independent choices however.

We recommend that the provider sources suitable picture menus to provide the appropriate support for people living with dementia or other memory impairment.

Most staff were trained to National Vocational Qualification (NVQ) level two or three in health and social care; or were working towards this. The majority of staff were up to date with mandatory training in subjects such as safeguarding, fire and health and safety. Staff had also received recent training about moving and handling people. However, we observed some poor practice in this area. Two staff did not put the brakes on wheelchairs when they were transferring people to them using a hoist. This created a risk of the wheelchair moving when the person was placed in it, which could cause an accident. One staff member held a wheelchair at a 45 degree angle to receive the person from the hoist. This was unsafe as the back wheels where not on the floor and it did not provide a stable surface to receive the person.

Although care plans detailed the sling size and hoist type to use for individuals, there was some confusion about this when we spoke with staff. For example; one staff member named the wrong size sling for a person who was being transferred from their bed to a chair, and a second staff member was unclear about the correct sling to use. Hoist equipment had pillows tied around their bases. Staff told us this was to prevent people from being injured during transfers. However, correct usage of the hoist should not result in injury to people. We read accident reports which recorded three occasions when people had received scratches or skin tears while being transferred with the hoist. This indicated that not all staff were fully competent in moving and handling techniques.

Only 11 staff out of 23 had received training about nutrition, and six of these sessions had taken place in 2011 and 2013. Our inspection highlighted that staff were not consistently promoting people's health and well-being by offering, encouraging and recording food and fluid intake.

Although staff had received regular supervision from the registered manager, this had not identified the gaps in staff knowledge or competency, which meant poor practice, had continued unchecked. The registered

manager said they were surprised that staff had not known about sling sizes and were not always transferring people safely. They said they had not had any concerns about this when conducting supervisions.

The lack of effective supervision and staff competency is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked to see how people's health care was managed. Some people had pressure or other wounds that required dressing or treatment. We found that the records about wound management were confusing to follow in care documentation. However, wounds had been photographed and measured appropriately and dressings applied regularly. One person had been identified as needing to be referred to the tissue viability nurse (TVN) on 9 January 2017 but by 16 January 2017 the referral had yet to be made by staff. This person had extensive wounds that required careful management. Although they were receiving antibiotic treatment, the TVN referral should have been made more promptly to ensure that this person received the best expert advice and treatment. Staff told us that the referral would be made that day.

Specific care plans were in place for people who had urinary catheters. Records showed that these had been monitored, flushed and changed in line with care plan directions; which helped to ensure people were kept comfortable and well. Staff showed good knowledge around catheter management. Care plans were also completed for people with diabetes. Blood sugar monitoring had been carried out when necessary but there was no guidance for staff about the safe upper and lower limits for people's readings. There was a risk that staff may not identify when a person needed urgent intervention because their blood sugars were either too high or too low. Although permanent staff were able to tell us about these limits, agency staff were sometimes used in the service and there was a risk that they may not be as knowledgeable about individuals.

We recommend that the provider updates diabetic care plans with information about individual blood sugar level parameters.

People were promptly referred to the GP if they showed signs of being unwell. During the first day of the inspection one person developed a very bad cough and staff contacted the GP. On the second day this person appeared a little better and staff told us the GP had prescribed antibiotics for a chest infection.

People's consent was sought both formally and informally before staff supported them with care and treatment. Care files contained consent forms that had been signed by people to record their agreement to various aspects of their care. We observed staff asking permission to go into people's bedrooms, and seeking verbal consent for example, when giving people medicines. Some people lacked mental capacity to make some decisions and in these cases, a detailed mental capacity assessment had been made. These are necessary to comply with the principles of the Mental Capacity Act (MCA) 2005. Staff had received up-to-date training about the MCA and worked in accordance with it. For example, staff offered one person straightforward choices by showing them two sets of clothing. This allowed the person to continue to express their choices, with staff support. Where people lacked capacity for more complex decisions, we saw evidence that best interest meetings had taken place with family and other professionals, to agree the right course of action to take on the person's behalf.

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 are called the Deprivation of Liberty Safeguards (DoLS). The registered manager understood their responsibilities around (DoLs) and had made a number of applications to the proper authority.

Requires Improvement

Is the service caring?

Our findings

We received mixed comments from people and relatives, but they were mainly positive. One person told us "Lovely girls [staff]; always very kind and have a chat to make sure I'm happy". Another person said "I can't complain at all, not one little bit. I'm well looked after and cared for and my son comes just to make sure of it". One relative told us "I can't fault the quality of care there; very caring staff". Another relative said "For some staff nothing is too much trouble and their warmth and kindness has been a great comfort. However one or two staff appear at times to be very unfriendly and unhelpful".

We observed kind and gentle interactions between some staff and people during the two days of the inspection. However, we also saw and heard occasions when staff were less caring. For example, one person coughed loudly while sitting close to another person. Staff shouted "Put your hand over your mouth" in an unpleasant tone. The registered manager heard this and told us that the staff member had been concerned about the spread of germs. However, this was an inappropriate way to speak to someone and did not show regard for the person's dignity by drawing attention to them in this way.

Other staff sometimes appeared brusque with people, for example when placing meals in front of them and not saying anything at all or just "Here's your lunch", without waiting to hear what people wanted to say or making even brief conversation. Another person had piles of possessions on their lunch table and staff made no attempts to gain consent to move them, but balanced the person's pudding bowl on a box of tissues there. There was a lack of thought and engagement at these times. On the second day of the inspection we observed a staff member supporting a person to eat their lunch. There was no conversation or interaction with them other than staff saying curtly "Right, next one" as they fed spoonfuls of lunch to them. This did not encourage the person and was undignified for them. The registered manager heard this happen but told us that the staff member was very kind and caring in general. A relative told us " I have encountered a lot of warm, caring, friendly staff at Barham House but my relative has been greatly upset by occasional hostile attitudes and nasty, bad-tempered comments".

The failure to consistently treat people with dignity is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other staff were discreet when asking people if they wanted to use the toilet and one person was gently helped with their blouse buttons which had come undone. Staff knocked on people's bedroom doors before entering and used people's preferred names out of respect for them. One person told us "I have to use a bed pan and the girls [staff] are so good and they never like to draw attention to the goings on, and cover me up nicely". Another person said "They show me respect or I give them what for. I'm not frightened to let them know". A relative remarked "Staff are always aware of [person's name] dignity and they show respect at all times". Staff put rollers into one person's hair and told us that they did so because it made the person "Feel good". They had recognised that it was important for this person's self-respect to present themselves well.

People told us they were supported to be as independent as possible. One person said "When my daughter comes, staff help me to go downstairs in the lounge and in the summer we go out- just a little piece of

independence". Another person said "It's difficult to be independent when I can't move off the bed unaided, but we [person and staff] always talk things through and decide what's best for me". A relative commented "[Person's name] cannot be independent to any degree as he is not capable, but what is good is that he has music on when he decides, gets up when he decides and chooses meals himself". Care plans recorded the tasks that some people could manage themselves and staff knew for example, which people liked to wash their own face and hands when receiving personal care. This meant that people received the level of support they wished for, but were given opportunities to make decisions and carry out tasks for themselves.

Records about people's care were kept confidentially and stored in the office when staff were not using them. When letters arrived for people who did not have the capacity to deal with them, they were stored securely until relatives visited. Staff were mindful of confidentiality when speaking with us and checked that is was acceptable to discuss people's care needs. Relatives told us that they could visit anytime they wished and that the quiet lounge was made available for them to have private time with their loved ones.

We looked to see how the service managed end of life care when necessary. There was nobody receiving end of life care during our inspection. Only five staff, including the registered manager and deputy manager had received specific end of life care training; but the most recent sessions had been held in 2013. There have been significant updates in the way in which end of life care is managed since that time. Care plans recorded the way in which people would be cared for in the last days and hours of life and the arrangements in place after death. However, this information was scant and did not include details about where people would like to be cared for or their wishes about who should be with them and any special requests. This meant that the provider could not be confident that they would be acting in accordance with people's hopes and wishes for their passing.

We recommend that the provider sources reputable end of life care training for staff and updates care plans with greater detail about people's choices and decisions.

Requires Improvement

Is the service responsive?

Our findings

We looked to see what was on offer for people to provide stimulation and social interaction. On both days of our inspection there were no organised activities at all. The registered manager told us that this was because activities staff was off sick. This staff member worked as care staff in the mornings and to provide activities on weekday afternoons. In their absence from work, there was no cover for the activities role and people had little by way of distraction.

People sat in the lounge in armchairs or wheelchairs all day and either slept or were staring ahead. There was no dining room at the service so people's meals were served to them in the lounge on over-bed tables. This meant there was no change of position or scene for people throughout, which might have added interest to their day. There was no background music during meals and the lunch period was almost silent. After we told the registered manager about this, music was played softly on the second day, but staff interaction remained poor.

The registered manager told us that there was usually a group activity in the afternoons. We read an activities programme which detailed games, bingo, sing-songs, crafts, ball games and sensory sessions on Mondays and Wednesdays. On Tuesdays and Thursdays 'Trips out' were advertised. This meant that activities for people who were unable to go on outings were limited to two days per week. One person told us "Not much to join in with; so I don't" and another person said "I like staying in my room and I'm happy watching television".

We read records of the activities individuals had engaged in, but these were minimal. For example; one person had a trip out in December and early January but on another day activities staff had documented 'Asked [person's name] if he had a nice Xmas and new year, he said he did and asked me. I said I did thanks'. This conversation had been recorded as an activity. The registered manager told us that they knew activities staff had more conversation than this with people, but it had not been documented. There were often two to four weeks between the activities documented for people. Although there were outings for some people who were able to enjoy them, there was very little provided on a daily basis to offer people stimulation. Responses to a recent survey showed that some people felt this was not enough. One relative had written 'More activities/social interaction and entertainment needed, taken out more' and others had rated activities as poor.

People who were nursed in bed or chose to stay in their rooms had TVs or a radio but there was no other form of stimulation for people other than staff visiting them at points during the day. All the staff we spoke with felt that there was not enough to keep people occupied and give them a better quality of life. A relative commented that aside from occasional outings, which were appreciated, "Very few activities indeed seem to be offered and there is not much opportunity for socialising with carers or other residents. As a result I believe my relative is more prone to boredom, loneliness and sadness".

The lack of appropriate activity to meet people's needs for stimulation is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans had generally been written in a person-centred way and detailed the ways in which individuals' care should be delivered. However, we found that these plans were not consistently carried out in practice. For example, one person's care plan stated that they should have 'Blue bed bumpers' on their bed to prevent possible injury from bed sides, but when we checked, there were no bumpers at all in place. The registered manager told us that these had been ordered. Other people had blank choking assessments in their care files or information that was not relevant to them. For example, one person was unable to go out on trips and this had been fully documented. However, the care plan then went on to state that the car for taking the person out should have an MOT, insurance and relevant licenses. This was an area for improvement.

However, staff knew people very well. Many of them had worked in the service in excess of ten years and could tell us about people's needs, wishes and personalities. Care files contained detailed information about people's lives before they began living in the service and the staff and registered manager were well-informed about people's families and characters. People had been involved in the development of their care plans and were able to express their views and preferences so that these were tailored for them. One person told us "I have my own care plan catered just for me so I can agree or disagree. I choose to stay in my room as I like to be private, but I can go downstairs to the lounge if I want to". Another person said "It's always me who chooses what I want to do and where I want to be". We observed another person eating their lunch on a table outside the kitchen and staff told us that this person liked to spend time there in private. The person told us they were happy with this arrangement; and staff had acted to meet this person's individual preferences.

Daily handover sheets recorded a summary of each person's conditions and care needs and were updated to document for example, if people had been prescribed antibiotics or were feeling unwell that day. The sheets also highlighted whether people had capacity to make their own decisions and gave information about which people had do not attempt resuscitation (DNAR) orders in place. This information helped staff to be aware of current and on-going instructions about people's care, and enabled them to respond accordingly.

We looked to see how complaints had been managed. The registered manager had maintained a log of any complaints or concerns raised, together with her responses to them. People told us that they knew how to make a complaint if necessary. One person said "I would be quite happy to make a complaint but I have never needed to". Another person told us "I know just who to talk to, but I wouldn't say I've needed to complain, more make requests now and then". A notice about how to make a complaint was on display in the reception area, so that relatives and visitors would also be made aware of the process to follow.

The registered manager had kept thank you cards and compliments from people and their families. One such card read 'All the family want to say how much we appreciate all the thought, hard work and care that you give'.

Inadequate

Is the service well-led?

Our findings

There had been inconsistent management oversight of the service. This had allowed some poor practice to develop and had adversely affected the safety and quality of the care provided in some areas. The registered manager had a deputy and some care staff were designated as seniors; with greater responsibility.

Risks to people had been documented but staff were not always carrying out mitigating actions to keep people safe and well. The provider and managers had not identified that this was happening prior to our inspection. Daily auditing of medicines had been put in place, but had been ineffective in highlighting the issues we found during the inspection. None of the daily medicine audits we reviewed reported any adverse findings. An infection control audit carried out by staff on 30 December 2016 had scored 100% but the registered manager had then found areas of the service that were not clean to an acceptable standard. We found that this was still the case when we inspected over two weeks later. The registered manager said that they planned to meet with domestic staff to discuss her concerns, but this had not yet happened and the service remained unhygienic in places. The deployment of staff had not taken into account that people spent long periods unattended in the lounge; despite there having been a number of incidents of people slipping from their chairs there while unsupervised. These areas had not been effectively managed.

There was some evidence that the registered manager had given directives to staff about the need to improve their practice. Minutes of a care staff meeting on 6 January 2017 showed that staff had been reminded to complete all food charts accurately, but ten days later during our inspection, we found that this instruction had not been carried out. The registered manager told us that they had had on-going difficulties with staff failing to complete tasks correctly. However, no further action had been taken by the registered manager to check that staff practice was appropriate. This extended to the behaviour of some staff. We observed some disrespectful attitudes which had been allowed to develop and had remained unchecked, by either the registered manager or other staff. This was indicative of a culture in which staff were not challenged by their peers.

The registered manager said that a consultant worked for the provider to give guidance about care quality matters. The consultant led management meetings and the provider had offered the registered manager a 'mock inspection' of the service by this consultant. However, they had declined the offer which meant the opportunity had been missed for an independent view on the quality and safety of the service with the potential to make improvements.

Feedback had been sought from people and their relatives by way of a suggestions book and a recent survey. However the registered manager told us that nobody ever wrote in the book and that the response to surveys was always very low. The survey had been issued in December 2016 and the registered manager had not yet analysed the results. We read feedback given in the few surveys that had been returned. Scores from one to five were given to different aspects of the service. Results varied but were mainly satisfactory to very good, with activities the only area that respondents had scored as '1', meaning poor.

There were no resident or relative meetings to garner views about the service. Given that the suggestions

book had not been used by people and relatives and that survey responses were low, meetings would have allowed the registered manager to invite feedback. This would help to measure the quality of the service and inform any improvements that might be needed. There had been no staff survey to establish the views of those working in the service. Seeking feedback from a variety of sources and in a number of ways would have allowed the provider to assess whether any changes could be made to make people's experiences better. We read records of the monthly key worker meetings which took place with people, but found that people's documented responses had been extremely similar. We asked the registered manager about this and they said that staff had asked people set questions, which had led to their replies being like this. For example, staff asked "Do you feel safe living here", people's replies "I feel safe here" Staff asked "Are you treated with respect by staff" and people replied "Staff respect my dignity and are friendly to me". The questions had not been sufficiently open so as to encourage meaningful responses and invite feedback to be freely voiced.

The lack of effective quality assurance processes is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives gave mostly positive feedback about the registered manager. One person told us "She's a lovely lady and ready for a chat" and another person said "A nice lady but always in a rush". A relative said "I never think twice about contacting [Registered manager's name] - she's marvellous. Another relative commented "The manager seems generally caring and kind. I have sometimes found her very approachable and sometimes much less so-probably due to stress and time pressures".

Staff told us that the registered manager was a good leader and that they "Muck in" if needed. There were regular staff meetings at which staff had the opportunity to raise any issues. Staff said that they generally worked well as a team but that some combinations of staff on duty worked better than others. The registered manager said that provider was supportive and always available to them if needed.

The registered manager is a trained nurse and told us that they kept up their registration with the Nursing and Midwifery Council (NMC). They carried out revalidation assessments to ensure that their nursing skills remained up-to-date and attended all training alongside staff so that they were informed to the same level. The registered manager participated in local care home forums and met and shared information with the manager of another of the provider's nursing homes. In these ways the registered manager kept abreast of developments in health and social care. However, these developments did not ensure that best practice guidance was followed at the service to ensure people received the care and support they needed.

Links with the local community had been forged to add a further dimension to people's lives and experiences. Church ministers had visited and work experience placements had been accepted from a service for people with learning disabilities, to help out in the laundry.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's individual needs were not always met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not consistently treated with dignity or respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Known risks to people had not been properly minimised. Medicines had not always been managed appropriately.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The service was not clean to an appropriate standard.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff deployment to meet people's needs.

Treatment of disease, disorder or injury

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance There had been insufficient oversight of the service to ensure safety and quality.

The enforcement action we took:

Warning notice