Libatis Limited

Barton Lodge

Inspection report

12 Longlands
Dawlish
Devon
EX7 9NF

Tel: 01626866724

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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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

What life is like for people using this service:
• People were not always protected from harm because risks were not always assessed. It was not clear on care documents what action staff should take if people became unwell due to specific care needs.
• Safe recruitment practises were not always followed and staff did not always receive an induction when they started working at the service.
• Staff required additional training to be able to meet people's changing needs. Many people in the service had advancing dementia and were becoming increasingly unwell. The training provided to staff did not reflect this changing level of need.
• The premises needed some improvements, the shower was not working and was full of linens and only one bath was working in the service. This was not accessible to all people using mobility aids as there was little space to move in the bathroom. Windows on the upper floor were not restricted posing the risk of people falling from a height.
• Quality assurance processes were not established or effective and did not pick up all the issues we identified. When concerns were noted by internal processes they were not always followed up on or learned from, to improve the service.
• People were not always supported to have maximum choice and control of their lives and were not always supported in the least restrictive way possible.
• People told us they sometimes would like more to do and more social contact. However, everyone we spoke with said they were happy living in the home and staff were kind and caring.
• Staff felt supported and listened to and spoke of working as a team and caring about people in the service.
• We found breaches in six legal requirements in areas relating to consent, safe care and treatment, premises, good governance, staffing, and recruitment.
• More information is in the detailed findings below.

Rating at last inspection: This service was rated good at the last inspection on 15 and 20 June 2016.

About the service: Barton Lodge is a residential care home providing personal care and accommodation to eight people over the age of 65 at the time of this inspection.

Why we inspected: This was a planned inspection based on the previous rating.

Enforcement: Please see the end of the report for any enforcement action.

Follow up: We have asked the service to provide us with an action plan with a specific deadline addressing the key concerns identified during this inspection. We will meet with the provider once this has been sent to us to check what improvements have been and are planned to be made.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our findings below.	**Requires Improvement**
Is the service caring? The service was caring. Details are in our findings below.	**Good**
Is the service responsive? The service was not always responsive. Details are in our findings below.	**Requires Improvement**
Is the service well-led? The service was not always well led. Details are in our findings below.	**Requires Improvement**

Barton Lodge

Detailed findings

Background to this inspection

The 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 checked whether the provider was 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.

Inspection team
The inspection team consisted of one adult social care inspector and one adult social care assistant inspector.

Service and service type
Barton Lodge is a residential care home in an adapted period property in the seaside town of Dawlish. It provides personal care and accommodation for up to eleven people over the age of 65. Some people may have dementia or need support with mobility. The service supported some people for short term respite or people after hospital discharge to rehabilitate before going back to their own homes.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did:
Before the inspection we gathered information we knew about the service. We did this by looking at the provider information return, a document the provider sends to us describing what they do well and planned improvements. We reviewed notifications sent to us about important events in the service. A notification must be sent to the Care Quality Commission every time a significant incident has taken place.

During the inspection we spoke with three people using the service. We sat with some people to observe interactions between them and staff as some people were unable to communicate with us verbally and tell

us about their care experience. We saw the lunchtime meal for two people and walked through all communal areas and looked in bathrooms and the kitchen.

We spoke with the chef, three staff members and the registered manager. We reviewed four staff files which contained recruitment, supervisions and some training information. We were given the contact details for four relatives of people living in the service and spoke with two after the inspection. We also spoke with two professionals who worked with the service.

We looked in detail at the care records for four people, this included their assessment, care planning, risk assessments and documents used to record their day to day care.

We looked at the safety of the environment and checked the windows of all the upstairs bedrooms for safety. We also reviewed accident and incident, safeguarding, complaints and fire files.

Requires Improvement

Is the service safe?

Our findings

People were not always safe and not always protected from avoidable harm.

Systems and processes.
• Recruitment processes were not robust. The service requested disclosure and barring (police) checks to see if potential staff were suitable to support vulnerable people. Some staff started work before these checks were in place. Full previous employment history for people who worked in care was not always sought.

The above information demonstrates a breach in Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Records for safeguarding training showed that only three out of the five staff had attended safeguarding training, the most recent one was in 2016. Staff did not demonstrate they would know what to do if they suspected abuse. Although we did not find evidence of any incidents that had taken place and had not been identified, this placed people at risk of avoidable harm.
• Incidents were recorded but there was no system in place to analyse incident information or identify trends.

Assessing risk, safety monitoring and management.
• People's needs were assessed before entering the service but this information was not always transferred onto risk assessments.
• A risk assessment for a person with diabetes did not contain enough information to support staff to mitigate the risk. When we asked staff what the recommended range for a safe blood sugar reading was for this person, they did not know and had to call the GP. Their records showed they had been outside of the recommended range several times in the last month and staff had not taken action to seek medical advice. This placed the person at risk of becoming unwell and receiving inappropriate care and treatment.
• Other risk assessments for people were no longer accurate or had large gaps in them. This meant there was not an accurate record of what staff should do in the event of an incident such as a fall or if a person became unwell due to their diabetes.

The above information demonstrates a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Building safety.
• Only one out of seven upstairs windows had a restrictor on it. This showed people were placed at risk of falling from a height. There were no checks for window safety as part of building safety checks. We asked the registered manager to arrange to make the windows safe immediately and shared with them where to find best practise guidance. They told us window restrictors were fitted in the days following the inspection.
• We identified several trip hazards with carpets being rucked in rooms and frayed in some communal areas. This was noted on our last inspection in June 2016 and we found repeat issues in this area.

The above information demonstrates a breach in Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing levels.
• People told us there were enough staff on duty to meet their needs. One person said they did not feel safe not knowing who was on the night shift if they became unwell or fell. We fed back to the registered manager people said they would feel safer if they knew who was working.
• Staff said they struggled at weekends and sometimes when cooking in the kitchen, they were called away to provide care. Staff told us some people had to wait for assistance but everybody had their basic needs met.
• Relatives said staff were very helpful but seemed rushed.
• On the day of our inspection staff were meeting people's basic needs, they all had their medicines administered, were dressed and had breakfast, lunch and drinks but staff were not able to spend quality time with people in their rooms. Some people said they were lonely.
• The service had several long-standing members of staff who had worked there for many years. One relative told us, "We see the same members of staff, we like the consistency."

We recommend that staffing levels are reviewed in line with people's dependency and their view on feeling lonely taken into consideration.

Preventing and controlling infection.
• Staff cleaned the service including bathrooms and people's rooms. Some rooms needed hoovering and carpets throughout the home were stained and required cleaning. Cleaning of the stairs and hallway carpet was arranged for the day after our inspection.
• Staff had not had infection control training. Some staff preparing food had not attended food hygiene training.

Learning lessons when things go wrong.
• The service could not demonstrate it was learning lessons when things went wrong. For example it did not have a system in place to review incidents such as falls or medicines errors and how the risks of these happening again could be mitigated.

Using medicines safely.
• Medicines were stored and administered safely and staff were efficient at checking whether records were complete and recording this in the communication book.
• However, where there were gaps in some medicine administration records as a result of staff forgetting to record administration, the management team did not take action to follow this up or prevent it from happening again. We discussed this with the registered manager, they said they would review their processes after our feedback to ensure they were following up any medicines discrepancies picked up from audits.

Requires Improvement

Is the service effective?

Our findings

People's care, treatment and support doesn't always achieve good outcomes, doesn't always promote a good quality of life and is not based on best available evidence

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 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).
• The registered manager and staff were unable to show their understanding of the MCA when we asked them how it was applied in the service. Where some people were having their liberty restricted this was not in line with the principles of the MCA. People were not having their capacity assessed and best interests decisions had not been made.
• One staff member told us "most" people living in the service had authorisations under the deprivation of liberty safeguards, records showed that no one did.
• Some Deprivation of Liberty applications had been completed. However, there was no record of a capacity assessments being carried out to make these decisions, and there was no evidence that one of the applications had been sent to the local authority.
• Staff had not received any training in how to assist people who might present with more challenging behaviours. Staff were unable to demonstrate knowledge of best practice when a person did not want to receive care.

The above information demonstrates a breach in Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• We saw care staff asking people for consent before supporting them with care tasks.

Staff skills, knowledge and experience.
• Care staff were not provided with the appropriate training to give them the knowledge and skills to provide effective care and treatment. A training plan was in place for 2018, however; most of the training identified as being needed, had not been provided.
• No care staff had attended training in how to support people with behaviour that challenged or infection control and only one staff member had attended equality and diversity training.
• Training records in core areas such as safeguarding and fire safety showed staff had not attended as frequently as the provider had specified in their policy. Two care staff who had worked at the service for over six months had not received fire safety training.
• There was no evidence of induction training for new staff and the Care Certificate was not being used for staff who were new to care. This is an approved set of training standards for staff who have not worked in

the care sector before. The manager told us they recognised there had been a lack of induction training and they intended to implement a system for this.
• Staff told us they received supervision twice a year, and could ask for support at any time. Records showed that not all staff were receiving supervision twice a year. For example, one staff member had worked at the service for over a year before a supervision was recorded.

The above information demonstrates a breach in Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs.
• People's needs were not always effectively met by the adaptation and design of the premises. One staff member told us that assisting people who needed to use mobility aids into the bathroom was very difficult because the doorway was too narrow and had a tight turn. One person's mobility needs made it "virtually impossible" to assist them to have a bath.
• There were no showers in the home, so people who were unable to use the bath or preferred a shower were restricted to using their sink or washing in bed.
• The service supported some people with advancing dementia. There was not adequate adaptation of the property and its decoration, to cater for the specific needs of people with dementia. This included a lack of appropriate signage and potential trip hazards where there was a change in flooring.

The above information demonstrates a breach in Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The communal area of the home was homely, with a variety of furnishings, books and magazines, although we only saw one person use this room.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law.
• Assessments of needs had information missing and some had not been updated for several years despite needs changing. The registered manager said there were plans to rewrite all the needs assessments, but only one had been completed at the time of our inspection.
• One person told us the service did not support them to improve their mobility whilst they were staying there for a short time and they were left in their room and felt isolated.
• Staff and the registered manager told us lots of people opted to stay in their rooms. One person told us they found it depressing doing nothing all day.

Eating, drinking, balanced diet.
• People told us they enjoyed the food, one person said, "There's never any food left over!" and another said, "There's always a beautiful lunch."
• People had drinks within reach in their rooms.
• On the day of our inspection there was a home cooked meal and the menu showed healthy options such as fresh soups made in the home.

Health care support.
• People were supported to attend health appointments.
• Referrals were made to appropriate services when people's needs changed.

Good

Is the service caring?

Our findings

The service involves and treats people with compassion, kindness, dignity and respect.

Treating people with kindness, compassion, dignity and respect.

Ensuring people are well treated and supported.
• We observed kind interactions between people and staff. Staff were appropriately affectionate and used humour to engage people.
• People told us the staff were "Lovely", "Wonderful" and "I couldn't ask for a kinder bunch."
• Staff spoke of people with affection and told us they felt they were part of a family in the service.

Supporting people to express their views and be involved in making decisions about their care.
• Relatives told us they were kept informed and involved in decisions. One relative said "I'm kept fully informed, they communicate well, and I will sing the praises of this place from the rooftops."
• People were given a questionnaire in June 2018 to express their views on the service as they had fed back they did not want to meet in a group.
• We did not see evidence of people contributing to the planning of their care. However, two people said they had no interest in seeing or hearing about a care plan and had told staff what they wanted and were happy with that.

Respecting and promoting people's privacy, dignity and independence.
• Staff knew how to provide personal care whilst respecting people's dignity.
• People and relatives all told us, staff were respectful and treated them with dignity.
• One person said they wanted to be left alone and only wanted support with specific things, and the service respected their wishes.
• The service did not always support people where it was appropriate to become more independent. For example, supporting people to walk more to encourage their mobility.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive personalised care that responded to their needs.

How people's needs are met.

Personalised care.
• People were not always supported to spend their time doing things that interested them or they had done before they moved to the service. For example, we looked at activity recording paperwork for one person we were told joined in most scheduled activities. They had only two activities per month recorded showing that people were engaged minimally in meaningful activity. This included going for a haircut and having a basic manicure. The activities were not designed around people's individual preferences.
• The registered manager told us people did not always enjoy taking part in group activities so staff tried to engage them in their rooms. Once a month the service was visited by a musician and a company who ran an exercise group.
• There were large gaps in people's biographical information and personal preferences in care files. This meant that any new or agency staff would struggle to find records of people's preferences.
• We asked the registered manager and staff how they supported people around any protected characteristics, they struggled to explain how they did this.
• Information was not displayed in an easy to read or large print format for those people who might benefit from it.
• We saw some preferences being met, for example for a person who liked chocolate they had chocolate to hand in their room.
• Staff were able to demonstrate they knew people's preferences and needs. However, they were not able to come up with any ideas for how to engage people in doing the things they enjoyed or introduce new activities into the service.
• Some people said they were happy being left alone, other people said they would like to socialise more.
• People's rooms were personalised with photographs of their families or furniture they had brought with them.
• Care plans were not always up to date and contained old information that made ascertaining people's current needs difficult.

We recommend that activity provision is reviewed with consideration to people's preferences.

Improving care quality in response to complaints or concerns.
• There was a system in place to record and review complaints
• Records showed there had been no recent complaints about the service.
• Relatives and people said they felt comfortable complaining and would go to any member of staff or the registered manager.

End of life care and support.
• One person we spoke with said, "They talked to me about what happens at the end." For some people their

advance care wishes were recorded.
• The registered manager and care staff told us one person was receiving care towards the end of their life. There was no mention of this in any care records or update to their care plan or risk assessment in light of their changing needs. We fed back to the registered manager that this person's needs were not accurately reflected in care documents.

Requires Improvement

Is the service well-led?

Our findings

Leadership and management do not always assure person-centred, high quality care and a fair and open culture.

Managers are not always clear about their roles, and do not understand quality performance, risks and regulatory requirements.
• The registered manager was not aware of all the situations where a notification would be needed to be sent to us. We signposted the registered manager to our website.
• We did not see evidence of adequate oversight and understanding of quality performance from the registered manager or provider. Some audits were taking place but the information gathered from these was not learned from and appropriate action was not always taken. This showed that the quality assurance processes were not robust.
• The was no process established to monitor the safety of the windows. The provider and registered manager were unaware it was their responsibility to ensure the windows were restricted appropriately and checked regularly to ensure their safety.
• The system to identify that risk assessments were up to date, was not effective. Many risk assessments needed updating, and in some cases, were not linked to other care documents, this made it unclear what the risks people faced were, and how to mitigate those risks.
• Records of people's needs and the care provided were not accurate or complete.

This demonstrates a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Care staff were clear about their roles and responsibilities.

Continuous learning and improving care.
• The registered manager had recently implemented new assessment tools for people's needs around falls and skin integrity. However, the outcomes of these were not linked to risk assessments or care plans and the recording of people's actual needs was inconsistent.
• The registered manager was starting to implement a framework for quality checks but this was still in the early stages and had not picked up many of the issues we observed.
• We saw a willingness to improve but the service needed to seek additional support to identify and action improvements.

Working in partnership with others.
• The service communicated frequently with the GP and other professionals when required.
• We recommend the registered manager link in with other registered managers in the area to access support and share best practise.

Management approach.
• Staff told us they felt listened to and supported by the registered manager and provider and they were

flexible around their personal needs.
• Staff said they felt like they were "one big family" and enjoyed the closeness of working in a small service and caring for people they knew well and working with other established staff members.
• People told us they thought the service was well run and knew who the registered manager was and said they were visible. People said they liked giving feedback on the service, one to one through talking to staff or completing the questionnaires.

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 11 HSCA RA Regulations 2014 Need for consent The service failed to gain consent of the relevant person for care and treatment and was not acting in accordance with the principles of the MCA 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service failed to assess the risks to the health and safety of service users of receiving the care or treatment and failed to do all that is reasonably practicable to mitigate any such risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance and safety checks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not established or operated effectively to assess monitor or improve the service, assess, monitor and mitigate risks to people. Records were not

accurate or complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not established and operated effectively to ensure that staff employed by the service met the requirements of this regulation. The information in Schedule 3 was not available.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The service failed to ensure staff had appropriate training, support and development to enable them to carry out the duties they were employed to perform.