Festival Care Homes Limited

Barleycroft Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Overall summary

This unannounced inspection took place over two days on 15 and 16 October 2014.

We last inspected this service on 18 and19 March 2014. During that inspection we found that the provider was in breach of the regulation that related to the safe storage, administration and disposal of medicines. People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. The provider sent us an action plan stating the steps they would take to address the issues identified.

During this inspection, we found that the arrangements for administering medicines were still not safe. Some people had not received all of their medicines because they were not in stock. The staff had not taken timely action to obtain the medicines. Staff did not have information to enable them to make decisions about when to give certain medicines to ensure that people received these when they needed and in a way that protected them against the risks associated with the unsafe use of medicines. As we have identified a

Summary of findings

continued breach of regulation we have taken action to ensure improvements were made to the service. You can see what action we told the provider to take at the back of the full version of the report.

Barleycroft is a purpose built 80 bed care home providing accommodation and nursing care for older people, including people living with dementia. There are three separate units. The first provides residential care, the second dementia nursing care and the third general nursing care. The service is accessible throughout for people with mobility difficulties and has specialist equipment to support those who need it. For example, hoists and adapted baths are available. When we visited 66 people were using the service.

Although there was a manager in post, due to administrative difficulties outside their control, the manager was not registered. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

People told us they felt safe at Barleycroft and that they were supported by kind, caring staff who supported them with respect. One person said, "Yes, I feel safe here because all the staff make me feel safe."

Staff had received Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training. Deprivation of Liberty Safeguards is where a person can be lawfully deprived of their liberties where it is deemed to be in their best interests or their own safety. Staff were aware that on occasions this was necessary. We saw that DoLS were in place for some people to keep them safe.

People lived in a clean, safe environment that was suitable for their needs.

People told us that the food was good and that they had a choice of food and drinks. We saw that people's nutritional needs were met and that if there were concerns about their eating, drinking or weight this was discussed with the GP and support and advice was received from the relevant healthcare professional. For example, the dietitian.

Staff received the support and training they needed to provide a safe appropriate service that met people's needs.

People knew how to raise concerns and told us that the quality of service had greatly improved since the manager had joined the service. They were asked for their feedback about the quality of service provided.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. Care provided was safe with the exception of medicines management. People did not always receive their medicines as staff had not taken timely action to ensure that it was in stock. People were at risk of pain and/or discomfort because of this.

Risks were assessed and addressed to keep people as safe as possible.

People lived in a safe environment and equipment was appropriately maintained to ensure that it was safe and ready for use when needed.

Is the service effective?

Good

The service was effective. People's healthcare needs were identified and monitored and action taken to ensure that they received the healthcare that they needed.

Systems were in place to ensure that people were not being unnecessarily or unlawfully deprived of their liberty.

People were supported by staff who received the training and support that they needed to safely and appropriately meet their needs.

People told us that they enjoyed the food and that there was a variety of nutritious food and drink on offer. We saw that staff supported people to have sufficient food and drink to maintain their health.

Is the service caring?

Good

The service was caring. People told us that the staff team were caring and treated them with dignity and respect. One person said, "If you have to live in a care home then this is a very good place to be."

At the end of their life people, and their relatives, were supported with kindness and compassion. A relative had written, "Thank you for the absolutely professional care that you gave to [our relative] during their final weeks."

Is the service responsive?

Good

The service was responsive. People and their relatives were listened to and their feedback acted upon. The service had a complaints procedure and action had been taken to address concerns and complaints.

People's care plans were reviewed on a monthly basis to ensure that they reflected their current needs. Care plans and risk assessments were also reviewed as needs changed.

Summary of findings

Is the service well-led?

Some aspects of the service were not well-led. The provider had not ensured that the outstanding actions from the previous inspection relating to medicines were addressed. People told us that the quality of the service provided had improved a lot since the manager had been in post. They were happy with the way in which the service was managed.

The management team monitored the quality of the service provided to ensure that people's needs were being met and that they were receiving the support that they needed and wanted.

Requires Improvement

Barleycroft Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 15 and 16 October 2014 and was unannounced on 15 October.

The inspection team consisted of a lead inspector, a second inspector, a pharmacist inspector, and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before our inspection, we reviewed the information we held about the home. We contacted the commissioners of the service and the local Healthwatch to obtain their views about the care provided in the home.

We spent time observing care and support in the communal areas, lounges and dining rooms, in each of the three units. We used the Short Observational Framework for Inspection (SOFI) which is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 16 people who used the service and 13 relatives. We also spoke with the manager, deputy manager/clinical lead, two heads of unit, the chef, the handyperson, an activities coordinator, two senior carers and four carers. We looked at 10 people's care records and other records relating to the management of the home. This included three sets of recruitment records, duty rosters, accident and incident records, complaints, health & safety and maintenance records, quality monitoring records and medicine records. We were also shown a copy of the quality monitoring visit report carried out by the Clinical Commissioning Group in September 2014.

Requires Improvement

Is the service safe?

Our findings

Care provided was safe with the exception of medicines management. When we visited this service on 18 and 19 March 2014 we found that the provider was in breach of the Regulation that related to medicines. People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. The provider sent us an action plan stating the steps they would take to address the issues identified.

At this inspection we checked the medicine administration records for 32 out of 68 people. We checked whether there were appropriate arrangements in place for safe administration of medicines.

We found that the systems in place for the administration of medicines were not safe. We saw that three people had not been given five prescribed medicines as these were out of stock and not available to be administered for a period of between two and five days. This meant that they had not received all their medicines as prescribed which, was a risk to their health and welfare. The management team carried out weekly medicines audits but issues highlighted were not followed up robustly. We saw that when random stock checks showed low or no stock for some medicines action was not taken to prompt reordering. Concerns identified in the audits were not responded to. Therefore appropriate arrangements were not in place to manage the risks associated with medicines.

There was no guidance for staff for the administration of medicines that were prescribed on an 'as required' basis or that should only be given under specific circumstances. There was no information about the circumstances under which these should be administered or the gap required between doses. People were therefore placed at risk of not receiving these medicines safely. This was because there was no information to enable staff to make decisions as to when to give these medicines to ensure people received these when they needed them and in a safe way.

The issues highlighted above evidence that there was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. As we have identified a continued breach of regulation we will make sure action is taken.

People told us that they felt safe living at the Barleycroft. One person said, "Yes I feel safe here because all the staff make me feel safe." Another said, "I do not feel at risk in any way." Visitors said that they had never had any concerns about the safety of their relatives. They told us they would be confident speaking to a member of staff or the manager of the home if they had any concerns.

Staff were aware of the safeguarding policies in place in order to protect people from abuse and demonstrated knowledge about different types of abuse. They told us that they had received safeguarding training. They were aware of the whistleblowing processes in place and told us that they would not hesitate to speak to the management about any concerns at work. Our records showed that the provider had told us about any safeguarding incidents and had taken appropriate action to make sure people who used the service were protected from abuse.

We found comprehensive risk assessments in the care plans we reviewed including personal fire evacuation plans for each person. The provider had appropriate systems in place in the event of an emergency. A fire risk assessment was in place and regular fire drills were carried out.

Staff were aware of the evacuation process and the procedure to follow in an emergency. They told us they were trained in resuscitation annually. There was an emergency contingency plan and an 'evacuation' box. This contained blankets, fluorescent vests and 'residents' information and was updated weekly. This meant that systems were in place to keep people as safe as possible in the event of an emergency arising.

People were cared for in a safe environment. The premises were in a good state of repair and we were shown the maintenance book where maintenance issues were logged and then addressed by the maintenance team. Equipment such as hoists, slings, mobility aids and pressure relieving aids were available. We checked the records and found that equipment was serviced and checked in line with the manufacturer's guidance. This included the fire alarm system and fire-fighting equipment. The records also confirmed that the maintenance person carried out weekly checks on hoists, pressure relieving mattresses, bedrails, and fire alarms to ensure that they were safe to use and in good working order.

The provider had a robust recruitment process in place to ensure that staff were suitable to work with vulnerable

Requires Improvement

Is the service safe?

adults. We found that necessary pre-employment checks were undertaken before they began work at the service. We looked at the files for four of the most recently recruited staff. They contained proof of identity, two references and evidence of criminal record checks.

In two of the three units we inspected people told us there were enough staff to provide the support they needed. One person told us, "Yes there are always enough staff and they came quickly." Another said, "The staff are attentive and when I use my call point come quickly." Staff we spoke with on these units also told us there were enough staff to provide people with the support they needed and to keep them safe. One unit lead told us, "Shifts are covered. One of the staff will cover if possible and if not we get agency. It's a good team." Another unit lead said, "Staffing levels are okay at present. If staff phone in sick we can usually get bank staff or agency."

One person said, "Very good place to live. The only problem is that they are a bit short of staff at times." A relative said, "There can be problems with staffing here and there, especially at weekends and sometimes at night." In the third unit people told us that they were concerned about the unit being short of staff on occasions, particularly at weekends. A member of staff on the same unit told us that the unit was usually well staffed but that it could be difficult to cover staff if there was a last minute cancellation. They gave the example of a weekend shift when an agency worker did arrive to cover a shift but was unwell and unable to work. Another member of staff told us, "Staffing has been fine lately. There used to be a problem at weekends but more staff have been recruited." Our observations during the inspection were that the staffing levels were sufficient when shifts were fully covered.

We spoke with the manager about staffing. They told us that there were usually enough staff to meet people's needs and that shortage of staff was not a regular occurrence. They were aware of the concerns in the third unit and confirmed that two nurses had been employed and would be starting work as soon as the necessary checks had been completed. In addition some weekend staff had also been recruited to ease the problem.

Good

Is the service effective?

Our findings

People we spoke with responded positively about the home and the care provided. A person who used the service said, "Yes, the staff know what they are doing. They know me and know what I need." A relative told us, "The staff are well trained and work as a team." We saw that a bereaved relative had written to thank staff for the care they had provided. This letter commented on staff skills and said, "We cannot speak highly enough of the nursing expertise and compassion."

People were supported by staff who had the necessary skills and knowledge to meet their assessed needs, preferences and choices. The provider was providing an effective service where staff were appropriately trained and had access to best practice information. Staff told us that they had received the necessary training to enable them to effectively care for people. This included induction when they first started working at Barleycroft and ongoing training. One member of staff told us, "The training is good. As well as the basic courses such as moving and handling and safeguarding we have additional training in more specialist areas. For example, tissue viability and medicines administration pumps." In addition to qualified nurses people were supported by staff who had already obtained or were in the process of obtaining health and social care qualifications in care. In one unit the nurse in charge informed us that all of the care staff in the unit had already obtained vocational qualifications in care. Another member of staff said, "Training is much better now and staff are more aware of what they are supposed to be doing."

Staff were appropriately supported in their roles through individual supervision meetings with their line manager to discuss work practice and any issues affecting people who used the service. Staff told us that they felt supported by the manager and the deputy. One member of staff said, "Both managers offer support and time and are approachable. They listen and offer advice."

Care staff had received Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training and were knowledgeable about people's capacity to make decisions but had limited understanding of the DoLS. The MCA is legislation to protect people who are unable to make decisions for themselves and DoLS is where a person can be lawfully deprived of their liberty where it is deemed to be in their best interests or for their own safety. The clinical staff and the management team were aware of this and knew how to obtain best interests decisions and how to apply for a DoLS authorisation. Records confirmed that when necessary applications for DoLS had been made to ensure that people were not being unnecessarily or unlawfully deprived of their liberty.

People were provided with a choice of suitable nutritious food and drink. The chef told us that a four week menu was provided by the organisation's head office but that she reviewed this and made changes based on feedback from people who used the service. For example, chicken curry had not been popular and therefore she had made a chicken casserole instead. The chef confirmed that most food was homemade and that the service was able to cater for a variety of dietary needs. For example, diabetic, gluten free and Halal. Therefore people were able to have meals that met their cultural, religious and health needs.

We looked at the menu and saw there was a choice of main meals each day plus a selection of alternatives that were always available. People chose their main meal the day before but could change their mind at any time. We observed that at lunch time two people said that they did not want what was on offer or what they had chosen the previous day. The chef talked to them and asked what they wanted. They chose fish and chips and this was cooked for them. People told us that they were happy with the choice and quality of meals provided. One relative said, "Yes there is a good choice of food and if they don't like it they are offered an alternative."

People were supported to be able to eat and drink sufficient amounts to meet their needs. We saw that people had water or squash at their side and had regular tea and coffee breaks during the day. Some people ate independently and others needed assistance from staff. We observed that staff appropriately supported people to eat and that they were not hurried. We saw that some people required a pureed diet and each food was pureed and served separately to enable them to enjoy the different tastes.

We saw that when there were concerns about a person's weight or dietary intake advice was sought from the relevant healthcare professional. We reviewed care plans and found evidence of monthly weights, nutritional risk assessments and input from dietitian and speech and language therapy when required. Food charts and fluid

Good

Is the service effective?

charts were completed to monitor people's intake. There were weekly 'nutrition' meetings and these were also attended by the chef who told us that they collected weekly weight information for people who were 'at risk' in this area and also received reports from senior staff of any changes. This enabled the chef to provide the correct diet to meet people's health needs.

People were supported to maintain good health and enabled to access healthcare services as needed. Daily records showed regular repositioning, mouth care, toileting and assistance with food and drink. Care plans were reviewed monthly and included fundamental aspects of care such as communication, continence, skin care, medicines and pain management, and personal hygiene.

We saw evidence that the GP visited weekly and that opticians, podiatrists and dentists also reviewed people regularly. People were positive about the support they received to meet their health needs. One person told us, "The doctor comes every week to see me."

We saw that the environment was designed to meet the needs of the people who used the service and was accessible throughout for people with mobility difficulties. Adapted baths and showers were available on all floors and specialised equipment such as hoists were readily available and used when needed. In line with guidance toilet door frames had been painted yellow and red toilet seats had been fitted to help people living with dementia to more easily identify these areas.

Good

Is the service caring?

Our findings

People and their relatives told us that staff were caring and treated them with respect. One person said, "The care is brilliant. They generally come when I call." Another commented, "They treat me with the utmost respect and dignity. They always knock on the door before they come in."

A relative said, "Very happy with the care and treatment. On the whole, consistent staff. Very friendly. No complaints. Wouldn't mind coming here myself when the time comes." Whilst another relative said, "I have seen the care go up and down but we are still here as the care is reasonably good."

We observed staff speaking to people in a polite and professional manner. People were treated with dignity and respect. Staff engaged with people whilst helping them at meals times. We also saw staff talking to people and explaining what they were doing before transferring them from chair to wheelchair. Staff discreetly explained to people that they were going to assist them with their personal care needs. One person told us, "It's brilliant. The carers do my personal hygiene in a respectful manner."

People and their relatives spoke highly of the relationship they had with those that cared for and supported them. They told us about the good interactions that they had with staff including the cook, manager, nurses and care staff. One person said, "If you have to live in a care home then this is a very good place to be."

Staff had a good knowledge of the people they cared for. They were able to tell us about people's personal preferences and interests. Relatives told us they were always made welcome and were able to visit whenever they wanted to. One relative told us, "The whole family are made to feel welcome and loved." Another made a point of finding us before they left because they wanted to tell us, "The staff are fantastic. They do everything I ask them. It's really good."

People, when possible, and their relatives were involved in decisions about their end of life care. For example, in one person's file, we saw a 'do not attempt resuscitation' document. Although the person had been unable to participate in the discussion, their relative, GP and lead nurse had discussed this and recorded their discussion and decision.

Staff had received end of life care training and provided caring support to people at the end of their life and to their families. We saw letters from bereaved relatives. One said, "Thank you for the absolutely professional care that you gave to [our relative] during their final weeks." Another commented, "We are touched and amazed at the ways staff found to make her last days special. Thank you for the loving care, attention to detail and respect shown to the family."

Good

Is the service responsive?

Our findings

People had life stories and personalised daily routines. We found these to be very specific. For example, one read, “Doesn’t like food cut up,” “Likes china mugs,” and “Likes subtitles on when watching TV”. Others explained people’s wake up and sleep routines. People’s knowledge and involvement in developing their care plan was mixed. For example, one person said, “I am very involved in my care plan and make my own decisions” and another told us, “I am satisfied with my care plan. If I was not I would get things changed.” A third person commented, “I do not have anything to do with my care plan.” However, we saw that people’s files contained information about their life history, likes, dislikes, religious beliefs and that these had been discussed with the individual and/or their relative. Individual preferences were documented to help staff to provide personalised care and support in line with the person’s wishes. For example, in one file it said, “I prefer a female carer” and “At night I like a cup of tea with one sugar.”

People were encouraged to make choices and to have as much control as possible over what they did and how they were cared for. People chose to either stay in their rooms or go to communal areas. They also chose whether they wanted same gender staff looking after them. We saw that people chose their meals including whether they wanted a cooked breakfast.

People’s care plans were reviewed on a monthly basis to ensure that they reflected their current needs. The service operated a ‘resident of the day’ system on each unit. This meant that their care plan was reviewed, their room was deep cleaned and they had a meal of their choice. Staff told us that the care plans, risk assessments as well as medicines were also reviewed each time people returned from a hospital stay. Care plans and risk assessments were also reviewed as needs changed. People were referred appropriately for input by specialists such as speech and language therapists and dietitians. We saw evidence of this in a care plan where the family, a speech and language therapist, dietitian and doctor were all involved in the decision as to the best course of action for the person concerned. Peoples healthcare needs were therefore identified and addressed to ensure that they received care and support that helped them to remain as healthy and comfortable as possible.

Arrangements were in place to meet people's social and recreational needs. Two activity workers were in post to support this. The second activity worker was recruited as a result of a request/feedback at a relatives meeting. We saw that activities were offered within the service and that on occasions people went out in the community with the staff and/or their relatives. On the second day of our visit a group of people went to the local shopping complex with staff and relatives. They told us that they had enjoyed their day.

Outside entertainers also visited. For example we saw that in October there was a singing group and also a travelling cinema visit. Celebrations were also organised and relatives joined these. In October this included a family quiz and a Halloween party. In house activities included bingo, memory games and hand massage. Although we could see that activities, outings and entertainment were arranged there were mixed views about these. Some people said that they were satisfied with the activities and others told us they would prefer more activities or in some cases more appropriate activities. One person said, “It is very boring. I know I am not a mixer but I get really bored.” Another told us, “A lady comes occasionally to try and get me to join in. I don’t fancy what’s on offer.” A third commented “I like watching television and prefer to stay in my room.”

There was guidance on how to make a complaint which was displayed around the service. We looked at the complaints file and saw that formal complaints had been dealt with in line with the provider’s policy and people had received a written response from the manager. Other complaints were dealt with by senior staff in the units. For example, one member of senior staff told us that a relative had said that clothing in the wardrobe and drawers was untidy. The senior had raised this with staff and they now checked this daily. The relative had since fed back that it was “perfect” now. One person and their relative told us that they had made a complaint about a member of staff and that this had been dealt with very promptly and to their satisfaction. They also told us that they were constantly giving feedback to staff. They added it was mostly positive but that they did give negative feedback also. People told us that they knew who to talk to if they were not happy about anything. Quarterly relatives meetings were held and this also gave people an opportunity to feed back about the service and any concerns they might have.

Requires Improvement

Is the service well-led?

Our findings

The manager had been in post for almost one year but due to administrative issues beyond their control had not been able to submit a completed application and therefore was not yet registered with CQC.

Some aspects of the service were not well led. Staff told us and records confirmed that the service was monitored to check that people were receiving the support and care that they required. This monitoring was carried out at different levels throughout the service. For example, senior staff in the units audited files and medicines. The manager and deputy (who was also the clinical lead) also monitored the service provided. For example, all accidents and incidents were audited and analysed every month to look for patterns and trends to see if lessons could be learnt. They also checked files and we saw that any points for action were recorded and given to the unit lead to action. The provider carried out monthly 'assessment and monitoring' visits. As part of this they got feedback from people and also checked records. They then wrote a short report of their findings which included key points for action. These actions were then followed up by the provider at the next monitoring visit. However, issues relating to the outstanding medicines actions from the last inspection were not identified during the monitoring process. The management team carried out weekly medicines audits but issues highlighted were not followed up robustly. We saw that when random stock checks showed low or no stock for some medicines action was not taken to prompt reordering. Concerns identified in the audits were not responded to. This placed people's health at risk.

People who used the service, their relatives and staff all told us that the service had improved greatly since the manager had been in post. One member of staff told us, "It's much better now but there is always room for improvement. It's better organised and we are more aware of what we are supposed to be doing. Staff are more appreciated. I get support when needed. The manager has been away a lot recently but they had put good structures in place for us to follow. It affected staff at first as we were used to them being here but things settled and you can always phone [the manager]." A relative told us, "I am happy with management, but not happy that the manager is taken away for long periods of times." The manager confirmed that they had been carrying out some peripatetic work for the provider but that they had still visited the service each week and had been available for telephone support. In addition the deputy manager had been at the service. Although people expressed concern about the managers' absence there was no evidence to indicate that the interim management arrangements had a negative impact on the service that people received.

There were clear management and reporting structures. There was a manager and a deputy in overall charge of the service. In addition to care workers and nurses, there were unit leaders and senior carers on each floor. We saw unit leaders and senior carers effectively carrying out duties such as allocation of tasks and coordinating staff breaks. One unit leader told us, "I check and monitor that people are being given choice and that their needs are met. The service had a positive person centred culture. One member of staff told us, "The manager is approachable and stresses the need for attention to detail. They have a good open door policy and are an assertive leader. This allows us to share ideas. The manager listens and offers advice." All staff we spoke with said their line manager was approachable and that the senior carers were also helpful. Staff said they could express their views without fear of reprisal. Therefore people were supported by staff who felt able to raise any concerns or ideas for improvement.

Relative and 'resident' meetings took place quarterly. Events, changes and any concerns were discussed at these meetings. We saw minutes of these meetings where people's views about the service, activities, menus and outings were sought. Feedback from people had been responded to in relation to the evening menu, the recruitment of a second activity worker and improved garden furniture. In addition there was a 'Barleycroft Gazette. This was a newsletter edited by the manager and one of the relatives. This also gave people information about what was happening at the service. For example, the September/October edition told people about trips that had taken place, forthcoming activities and company news.

The provider also sought feedback from relatives and people who used the service through an annual quality assurance survey in the form of questionnaires. The next survey was due to be sent out in November 2014 and the manager told us that this would be used to monitor the

Requires Improvement

Is the service well-led?

success and effectiveness of the changes that had been introduced during the year. Therefore there were a number of different ways by which people could give their feedback about the quality of service provided.

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 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines Service users were not protected against the risks associated with the unsafe use and management of medicines. Systems were not in place to ensure that they received their medicines safely. Regulation 13.

The enforcement action we took:
A warning notice was served under Section 29 of the Health and Social Care Act 2008. The date for compliance with this was 12th December 2014.